DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 424

[CMS-1282-P]

RIN 0938-AN65

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2006, as required by statute. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), relating to Medicare payments and consolidated billing for SNFs. As part of this year’s annual update, we are proposing to

introduce refinements in the Resource Utilization Groups, version III (RUG-III), the case-mix classification system used under the SNF PPS.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 12, 2005.

ADDRESSES: In commenting, please refer to file code **CMS-1282-P**. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. Electronically. You may submit electronic comments on specific issues in this regulation to http://www.cms.hhs.gov/regulations/ecomments. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. By mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1282-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore, Maryland address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201; or
7500 Security Boulevard,
Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "**SUPPLEMENTARY INFORMATION**" section.

FOR FURTHER INFORMATION CONTACT:

Ellen Gay, (410) 786-4528 (for information related to the case-mix classification methodology, and for information related to swing-bed providers).

Jeanette Kranacs, (410) 786-9385 (for information related to the development of the payment rates, and for information related to the wage index).

Bill Ullman, (410) 786-5667 (for information related to coverage requirements, level of care determinations, consolidated billing, and general information).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist

us by referencing the file code **CMS-1282-P** and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public website as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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In addition, because of the many terms to which we refer by abbreviation in this proposed rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ADL	Activity of Daily Living
AHE	Average Hourly Earnings
ARD	Assessment Reference Date
BBA	Balanced Budget Act of 1997, Pub. L. 105-33

BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113
BEA	(U.S. Department of Commerce) Bureau of Economic Analysis
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554
CAH	Critical Access Hospital
CBSA	Core-Based Statistical Area
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMSA	Consolidated Metropolitan Statistical Area
CPT	(Physicians') Current Procedural Terminology
DRG	Diagnosis Related Group
FI	Fiscal Intermediary
FR	Federal Register
FY	Fiscal Year
GAO	Government Accountability Office
HCPCS	Healthcare Common Procedure Coding System
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
IFC	Interim Final Rule with Comment Period
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review File

MIP	Medicare Integrity Program
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173
MSA	Metropolitan Statistical Area
NECMA	New England County Metropolitan Area
OIG	Office of Inspector General
OMRA	Other Medicare Required Assessment
PCE	Personal Care Expenditures
PMSA	Primary Metropolitan Statistical Area
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RAVEN	Resident Assessment Validation Entry
RFA	Regulatory Flexibility Act, Pub. L. 96-354
RIA	Regulatory Impact Analysis
RUG	Resource Utilization Groups
SCHIP	State Children's Health Insurance Program
SNF	Skilled Nursing Facility
STM	Staff Time Measure
UMRA	Unfunded Mandates Reform Act, Pub. L. 104-4

I. Background

On July 30, 2004, we published a notice in the **Federal Register** (69 FR 45775) that set forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2005. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for SNFs.

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (the BBA) amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to Medicare beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. In this proposed rule, we propose to update the per diem payment rates for SNFs for FY 2006. Major elements of the SNF PPS include:

- Rates. Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates were adjusted annually using a SNF market basket index. Rates were case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG-III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). The rates were also adjusted by the hospital wage index to account for geographic variation in wages. (In section II.C of this preamble, we discuss the wage index adjustment in detail.)

Correction notices were published in the **Federal Register** on October 7, 2004 (69 FR 60158) and on December 30, 2004 (69 FR 78445), announcing corrections to several of the wage factors. Additionally, as noted in sections I.C through I.E of this proposed rule, section 101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA also affect the payment rate.

- Transition. The SNF PPS included an initial 3-year, phased transition that blended a facility-specific payment rate with the Federal case-mix adjusted rate. For each

cost reporting period after a facility migrated to the new system, the facility-specific portion of the blend decreased and the Federal portion increased in 25 percentage point increments. For most facilities, the facility-specific rate was based on allowable costs from FY 1995; however, since the last year of the transition was FY 2001, all facilities were paid at the full Federal rate by the following fiscal year (FY 2002). Therefore, as discussed in section I.F.2 of this proposed rule, we are no longer including adjustment factors related to facility-specific rates for the coming fiscal year.

- Coverage. The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because RUG-III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures involving level of care determinations with the outputs of beneficiary assessment and RUG-III classifying activities. We discuss this coordination in greater detail in section II.F of this preamble. Moreover, the Part A SNF benefit has not only level of care requirements, but also a set of technical, or "posthospital" requirements as well. In section VI of this preamble, we discuss one aspect of the

technical requirement for a qualifying prior inpatient hospital stay of at least 3 consecutive days, on which we invite comment.

- Consolidated Billing. The SNF PPS includes a consolidated billing provision (described in greater detail in section IV of this proposed rule) that requires a SNF to submit consolidated Medicare bills for almost all of the services that its residents receive during the course of a covered Part A stay. (In addition, this provision places the Medicare billing responsibility for physical, occupational, and speech-language therapy that the resident receives during a noncovered stay with the SNF.) The statute excludes from the consolidated billing provision a small list of services--primarily those of physicians and certain other types of practitioners--which remain separately billable to Part B by the outside entity that furnishes them.

- Application of the SNF PPS to SNF services furnished by swing-bed hospitals. Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a

swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, those swing-bed SNF services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section V of this proposed rule.

B. Requirements of the Balanced Budget Act of 1997 (the BBA) for Updating the Prospective Payment System for Skilled Nursing Facilities

Section 1888(e)(4)(H) of the Act requires that we publish in the **Federal Register**:

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the FY.

2. The case-mix classification system to be applied with respect to these services during the FY.

3. The factors to be applied in making the area wage adjustment with respect to these services.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG-III classification structure (see section II.F of this proposed rule).

Along with a number of other revisions discussed later in this preamble, this proposed rule provides the annual updates to the Federal rates as mandated by the Act.

C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA)

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2000 (65 FR 46770). In particular, section 101 of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG-III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). Under the law, this temporary increase remains in effect until the later of October 1, 2000, or the implementation of case-mix refinements in the PPS. A discussion of the case-mix refinements that we are proposing to implement appears in section II.B of this proposed rule. Section 101 also included a 4 percent across-the-board increase in the adjusted Federal per diem payment rates each year for FYs 2001 and 2002, exclusive of the 20 percent increase.

We included further information on all of the provisions of the BBRA that affect the SNF PPS in Program

Memoranda A-99-53 and A-99-61 (December 1999), and Program Memorandum AB-00-18 (March 2000). In addition, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the July 31, 2001 final rule (66 FR 39562), we made conforming changes to the regulations in 42 CFR section 413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA)

The BIPA also included several provisions that resulted in adjustments to the PPS for SNFs. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2001 (66 FR 39562) as follows:

- Section 203 of the BIPA exempted critical access hospital (CAH) swing-beds from the SNF PPS; we included further information on this provision in Program Memorandum A-01-09 (January 16, 2001).
- Section 311 of the BIPA eliminated the 1 percent

reduction in the SNF market basket that the statutory update formula had previously specified for FY 2001, and changed the 1 percent reduction specified for FYs 2002 and 2003 to a 0.5 percent reduction. As discussed in section II.B of this proposed rule, this provision also required us to conduct a study of alternative case-mix classification systems for the SNF PPS, and to submit a report to the Congress on the results of the study.

- Section 312 of the BIPA provided for a temporary 16.66 percent increase in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002. This section also required the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. GAO issued this report (GAO-03-176) in November 2002.
- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical, occupational, and speech-language therapy) furnished to SNF residents during noncovered stays, effective January 1, 2001.
- Section 314 of the BIPA adjusted the payment rates for all of the 14 rehabilitation RUGs (RUC, RUB, RUA, RVC, RVB,

RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB, and RLA), in order to correct an anomaly under which the existing payment rates for three particular rehabilitation RUGs--RHC, RMC, and RMB--were higher than the rates for some other, more intensive rehabilitation RUGs. Under the BIPA adjustment, the temporary increase that section 101(a) of the BBRA had applied to the RHC, RMC, and RMB rehabilitation RUGs was revised from 20 percent to 6.7 percent, and the BIPA adjustment also applied this temporary 6.7 percent increase to each of the other 11 rehabilitation RUGs.

- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes.

We included further information on several of these provisions in Program Memorandum A-01-08 (January 16, 2001).

E. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA)

A provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) resulted in a further adjustment to the PPS for SNFs. Specifically, section 511 of the MMA amended paragraph (12) of section

1888(e) of the Act to provide for a temporary 128 percent increase in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. As discussed in Transmittal #160 (Change Request #3291, April 30, 2004), this add-on applies to claims with diagnosis code 042. Like the temporary add-on payments created by section 101(a) of the BBRA (as amended by section 314 of the BIPA), this special AIDS add-on was not intended to remain in effect indefinitely. As amended by section 511 of the MMA, section 1888(e)(12)(B) of the Act specifies that this temporary increase for patients with AIDS is to remain in effect only until ". . . such date as the Secretary certifies that there is an appropriate adjustment in the case mix . . . to compensate for the increased costs associated with [such] residents . . . ." As discussed elsewhere in this proposed rule, we are not proposing at this time to address the issue of such certification and, accordingly, the temporary add-on payments created by section 511 of the MMA will remain in effect during FY 2006.

The law further provided that the 128 percent increase in payment under the AIDS add-on is to be " . . . determined without regard to any increase" under

section 101 of the BBRA (as amended by section 314 of the BIPA). As explained in the MMA Conference report, this means that if a resident qualifies for the temporary 128 percent increase in payment under the special AIDS add-on, "the BBRA temporary RUG add-on does not apply in this case . . . ." (H.R. Conf. Rep. No. 108-391 at 662). The AIDS add-on was also discussed in Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp .

In addition, section 410 of the MMA contained a provision that affects the consolidated billing requirement, which we discuss in section IV of this proposed rule.

F. Skilled Nursing Facility Prospective Payment--General Overview

The Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, we pay SNFs through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered

SNF services include post-hospital services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA) but furnished to Medicare beneficiaries in a SNF during a covered Part A stay. A complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252).

1. Payment Provisions--Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of PPS (the 15-month period beginning July 1, 1998) using a SNF market basket, and then standardized for the costs of facility differences in case-mix and for geographic variations in

wages. Providers that received new provider exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates, as well as costs related to payments for exceptions to the routine cost limits. In accordance with the formula prescribed in the BBA, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas. In addition, we adjusted the portion of the Federal rate attributable to wage-related costs by a wage index.

The Federal rate also incorporates adjustments to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. This classification system, Resource Utilization Groups, version III (RUG-III), uses beneficiary assessment data from the Minimum Data Set (MDS) completed by SNFs to assign beneficiaries to one of 44 RUG-III groups. The May 12, 1998 interim final rule (63 FR 26252) included a complete and detailed description of the RUG-III classification system, and a further discussion appears in section II.B of this proposed rule.

The Federal rates in this proposed rule reflect an update to the rates that we published for FY 2005 equal to the full change in the SNF market basket index. According to section 1888(e)(4)(E)(ii)(IV) of the Act, for FY 2006, we would update the rate by adjusting the current rates by the full SNF market basket index.

2. Payment Provisions--Initial Transition Period

The SNF PPS included an initial, phased transition from a facility-specific rate (which reflected the individual facility's historical cost experience) to the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Accordingly, starting with cost reporting periods beginning in FY 2002, we base payments entirely on the Federal rates and, as indicated in section II.G of this proposed rule, we no longer include adjustment factors related to facility-specific rates for the coming fiscal year.

G. Use of the Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered SNF services. The SNF market basket index is used to update the Federal rates on an annual basis. The final rule published on July 31, 2001 (66 FR 39562) revised and rebased the market basket to reflect 1997 total cost data.

In addition, as explained in the FY 2004 final rule (68 FR 46058, August 4, 2003) and in section III.B of this proposed rule, the annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error. This adjustment takes into account the forecast error from the most recently available fiscal year for which there are final data, and is applied whenever the difference between the forecasted and actual change in the market basket exceeds a 0.25 percentage point threshold. For FY 2004 (the most recently available fiscal year for which there are final data), the estimated increase in the market basket index was 3.0 percentage points, while the actual increase was 3.1 percentage points. Therefore, the payment rates for FY 2006 do not

include a forecast error adjustment, as the difference between the estimated and actual amounts of change does not exceed the 0.25 percentage point threshold. Table 1 below shows the forecasted and actual market basket amounts for FY 2004.

Table 1 - FY 2004 Forecast Error Correction for CMS SNF Market Basket

Index	Forecasted FY 2004 Increase*	Actual FY 2004 Increase**	FY 2004 Forecast Error Correction***
SNF	3.0	3.1	0.0

*Published in August 4, 2003 Federal Register; based on second quarter 2003 Global Insight/DRI-WEFA forecast.
**Based on the fourth quarter 2004 Global Insight/DRI-WEFA forecast.
***The FY 2004 forecast error correction will be applied to the FY 2006 PPS update. Any forecast error less than 0.25 percentage points is not reflected in the update.

II. Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities

A. Federal Prospective Payment System

This proposed rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2005. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

1. Costs and Services Covered by the Federal Rates

The Federal rates apply to all costs (routine, ancillary, and capital-related costs) of covered SNF services other than costs associated with approved educational activities as defined in §413.85. Under section 1888(e)(2) of the Act, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program), as well as all items and services (other than those services excluded by statute) that, before July 1, 1998, were paid under Part B (the supplementary medical insurance program) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (These excluded service categories are discussed in greater detail in section V.B.2 of the

May 12, 1998 interim final rule (63 FR 26295 through 63 FR 26297)).

2. Methodology Used for the Calculation of the Federal Rates

The proposed FY 2006 rates would reflect an update using the full amount of the latest market basket index. The FY 2006 market basket increase factor is estimated to be 3.0 percent. Consistent with previous years, this factor may be revised in the final rule when later forecast data are available. For a complete description of the multi-step process, see the May 12, 1998 interim final rule (63 FR 26252). We note that in accordance with section 101(a) of the BBRA and section 314 of the BIPA, the existing, temporary increase in the per diem adjusted payment rates of 20 percent for certain specified clinically complex RUGs (and 6.7 percent for rehabilitation RUGs) remains in effect until the implementation of case-mix refinements. (A discussion of the case-mix refinements that we now propose to implement appears in section II.B of this preamble.)

We used the SNF market basket to adjust each per diem component of the Federal rates forward to reflect cost increases occurring between the midpoint of the Federal fiscal year beginning October 1, 2004, and ending

September 30, 2005, and the midpoint of the Federal fiscal year beginning October 1, 2005, and ending September 30, 2006, to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the payment rates for FY 2006 are updated by a factor equal to the full market basket index percentage. The rates would be further adjusted by a wage index budget neutrality factor, described later in this section. The unadjusted rates are the same under both the existing 44 group RUG classification system and the proposed RUG-53 classification system. Tables 2 and 3 reflect the updated components of the unadjusted Federal rates for FY 2006.

Table 2
FY 2006 Unadjusted Federal Rate Per Diem
Urban

Rate Component	Nursing - Case-Mix	Therapy – Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$137.44	$103.53	$13.63	$70.15

Table 3
FY 2006 Unadjusted Federal Rate Per Diem
Rural

Rate Component	Nursing - Case-Mix	Therapy – Case-Mix	Therapy-Non-Case- Mix	Non-Case-Mix
Per Diem Amount	$131.30	$119.38	$14.56	$71.45

B. Case-Mix Adjustment and Other Clinical Issues

[If you choose to comment on issues in this section, please include the caption "Case-Mix Adjustment and Other Clinical Issues" at the beginning of your comments.]

Under the BBA, we must publish the SNF PPS case-mix classification methodology applicable for the next Federal FY before August 1 of each year. As discussed in the following sections, we propose to begin utilizing a refinement to the RUG-III case-mix classification system applicable to the SNF PPS during FY 2006, and we specifically solicit comments on the proposed refinement.

1. Background

The SNF PPS replaced the cost-based structure that had been in effect since the inception of the Medicare program. Under the SNF PPS, providers have more flexibility in the use of Medicare funds but are responsible not only for furnishing the full range of services to Medicare beneficiaries, but for the cost effectiveness of their purchasing decisions. Like the inpatient hospital PPS, reimbursement for all services, including therapy and other ancillaries such as diagnostic tests, supplies, and pharmacy, were for the first time included in the SNF Part A "bundle of services" and reimbursed directly to the

SNF rather than to the actual entity furnishing the service.

In addition, in response to over a decade of rapidly rising Medicare SNF payments, the SNF PPS instituted controls to adjust for identified overutilization and inflated charge structures for therapy and other ancillary services. By restructuring the payment system to reflect a more appropriate expenditure level, there was an aggregate decrease in Medicare expenditure levels for the first SNF PPS year. Providers responded to the SNF PPS by restructuring their operations and practice patterns in an effort to adapt to the new payment structure and incentives.

These rapid changes in facility practices and Medicare payment also generated significant concerns that the transition to a prospective payment system would impede access for beneficiaries with complex medical needs and, by decreasing aggregate payments to SNFs, negatively affect the quality of care in nursing homes across the country. The research presented in this proposed rule was initiated as part of a broad-based effort to investigate and respond to access, quality, and payment concerns raised by industry, advocates, and other stakeholders.

During the course of this effort, CMS developed tools to monitor and evaluate quality of care that are now integral components of our program oversight activities, including the use of Quality Indicators, Quality Measures, and Nursing Home Compare. As discussed later in this section, the development of these new capabilities has also positioned us to move forward in new areas. The refinements discussed in this section are based on research originally conducted by Abt Associates (and later validated by the Urban Institute) that was initiated immediately after the introduction of the SNF PPS in 1999.

In the BBRA, the Congress acted to address these access and quality concerns by enacting a series of temporary payment adjustments. At present, only one of these payment adjustments is still in effect, a 20 percent increase in the per diem adjusted payment rates for 12 complex medical RUG-III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1,) and a 6.7 percent increase to all 14 rehabilitation groups. This legislation specified that the payment adjustments would continue until the later of: 1) October 1, 2000, or 2) implementation of a refined case-mix classification system under section 1888(e)(4)(G)(i) of the Act that would better account for medically complex patients.

As we noted in the SNF PPS proposed rule for FY 2001 (65 FR 19190, April 10, 2000), this mandated rate increase was intended to serve as a temporary, interim adjustment to the payment rates and RUG-III case-mix classification system as published in the final rule of July 30, 1999, until implementation of the case-mix refinements described in the legislation. In that FY 2001 proposed rule, we included a proposal for an extensive, comprehensive set of refinements to the existing case-mix classification system that collectively would have resulted in expanding the existing 44-group structure to well over 150 groups.

The speed with which we conducted this initial evaluation of the SNF PPS demonstrated our commitment to ensuring the accuracy and equity of the new payment system, but the evaluation had important limitations. Comprehensive SNF PPS data were not yet available, and the research was conducted using 1995-1997 data housed in a large, cross-linked research database collected from only six states that had implemented a RUG-III payment system prior to July 1998 (either through the Federal case-mix demonstration project or for state Medicaid payment). These limitations were explained in the proposed rule along with our plans to validate the data using a national SNF PPS database (65 FR 19193, April 10, 2000).

In conducting the validation analyses, it became clear that the introduction of the SNF PPS and SNF consolidated billing had caused changes in facility practice patterns and billing. Some of these changes could also have been related to the use of a national database and to changing industry practices during the early stages of the SNF PPS implementation. While it was still true that beneficiaries requiring both rehabilitation and extensive medical services used greater amounts of ancillary services, the distribution patterns for those high-cost ancillaries (such as medications and respiratory therapy) had changed from the patterns in the six-state data. These results, in conjunction with the high degree of intra-group and inter-group variability in ancillary utilization identified in both the initial and validation analyses, raised new questions that needed to be addressed prior to implementing refinements. For these reasons, we decided not to implement such refinements at that time. (See the FY 2001 final rule, 65 FR 46773, July 31, 2000.)

Several months later, the Congress enacted the BIPA. Of the various provisions of this legislation that addressed the SNF PPS, one directive also addressed the future development of the SNF PPS. Specifically, section 311(e) of the BIPA directed us to conduct a study

of the different systems for categorizing patients in Medicare SNFs in a manner that accounts for the relative resource utilization of different patient types and to issue a report with any appropriate recommendations to the Congress.

Based upon the broad language describing the purpose of this study, and the multi-year timeframe provided for conducting it, we believe that the Congress clearly intended for this study to address comprehensive changes, by evaluating a number of different classification systems and considering the full range of patient types. In contrast, since the BBRA specifically ties the duration of its temporary payment increases to the implementation of a case-mix refinement that would "better account for medically complex patients," we believe that even case-mix refinements of a more incremental nature would meet this more targeted mandate to better account for medically complex patients, and need not await the completion of the broader changes envisioned in the BIPA provision.

Moreover, ongoing analysis of the SNF PPS showed that providers have adjusted to it, and that the SNF PPS rates have generally covered the cost of care to Medicare beneficiaries. For example, in its March 2005 report, MedPAC estimated 2005 profit margins for freestanding SNFs

of 13 percent. In this environment, it is appropriate to reevaluate the need for maintaining payment adjustments that were always intended to be temporary.

2. Case-Mix Refinement Research

a. Data Sources and Analyses

In July 2001, we awarded a contract to the Urban Institute (Urban) for performance of research to aid us in making refinements to the case-mix classification system under section 1888(e)(4)(G)(i) of the Act and starting the case-mix study mandated by section 311(e) of the BIPA. The first phase of the contract focused on developing options for refining the case-mix classification system under section 1888(e)(4)(G)(i) of the Act to account for medically complex patients. As part of this research, Urban updated and broadened the database created for the previous refinement analyses by using 1999 matched MDS and SNF claims, and applied the latest cost report data (1998 and 1999) to estimate costs more accurately for non-therapy ancillary and other services.

We then used this updated and broadened database to replicate and validate the earlier studies conducted by Abt. The study used Medicare SNF claims data for calendar year 1999 and MDS data from our National MDS Repository. We matched the claims to the MDS assessments upon which

they were based, yielding approximately 2.7 million MDS segments, resulting in every national facility that billed Medicare for a Part A SNF stay in 1999 being represented in the database. We allocated the non-therapy ancillary costs to the portion of the stay in which they were most likely to have been incurred according to a set of decision rules. We performed comparative analyses of cost and charge data to other existing administrative data sets in order to establish the validity of these data. We also performed a further regression analysis of costs and RUG-III groups.

In addition, we constructed anew the case-mix indexes using our Staff Time Measurement (STM) study data. The STM data were collected in 1990, 1995, and 1997, and are described in the May 12, 1998 interim final rule (63 FR 26252) that implemented the SNF PPS.

Urban then analyzed 270,215 records, a 10 percent sample of this updated and broadened database. As expected, our analyses again verified that non-therapy ancillary costs are higher for Medicare beneficiaries who classify into the Extensive Services category than for those who classify to other categories. In these analyses, Urban found that the addition of a combined Rehabilitation plus Extensive group improved the predictive power of the model. These results were very similar to the preliminary

Abt results discussed in our FY 2001 proposed rule, and provided validation for the preliminary Abt analyses (that is, both studies showed an increase in the R-square (explanation of variance) for non-therapy ancillaries from approximately 4.1 percent in the 44-group model to 8 percent in the 58-group model that added nine Rehabilitation plus Extensive groups).

Urban then replicated its results with 2001 data using the same analytic protocols. In this study, Urban found that the addition of a new RUG-III Rehabilitation plus Extensive category was consistent with the prior research. Urban used a 163,386 record test sample and found that the R-square for non-therapy ancillaries improved to 9.5 percent from the previous result of 4.1 percent mentioned above. The analyses were repeated on a 170,253 record validation sample with a comparable result; that is, an R-square of 10.3 percent.

While maintaining the general structure of the RUG-III system, we found that the most viable way to refine the system at the present time would be to add groups to the top of the hierarchy to capture beneficiaries who qualify for both the Extensive Services category and the Rehabilitation Therapy category. In addition, beneficiaries who qualify for Extensive Services and

receive rehabilitation services have assumed a larger percentage of the Medicare patient population in SNFs in recent years. Therefore, we believe that the RUG-III case-mix classification system can provide even more accurate payment for these beneficiaries if refined to create a new RUG-III category for beneficiaries who qualify for both the Extensive Services and Rehabilitation Therapy categories.

b. Constructing the New RUG-III Groups

Our research findings showed little or no correlation between the groups within the Extensive Services category (that is, SE1, SE2, SE3) and the level of rehabilitation services used. For this reason, the structure for this new hierarchy level would closely mirror that of the existing Rehabilitation Therapy groups. Normally, this methodology would result in the creation of 14 new groups, the number that was originally proposed in the FY 2001 proposed rule. However, for the reasons discussed below, the more recent research (Urban 2003) has shown that a smaller number of RUG-III groups are sufficient to address the needs of beneficiaries eligible for a new RUG-III category, Combined Rehabilitation and Extensive Care.

First, we found that several of the groups had very few beneficiaries assigned to them. In fact, no beneficiaries at all were assigned to several of the lowest

ADL score rehabilitation groups. Second, under the present structure, each Rehabilitation group is sub-divided into three levels based on the activities of daily living (ADL) score. The lowest level ADL score for the Rehabilitation groups is either 4-7 or 4-8, and very few beneficiaries currently classify into those groups. No beneficiaries who would qualify for the proposed newly created groups would classify into such a low ADL score level, as a minimum ADL score of seven is required for classification into an Extensive Care group.

Therefore, it appears that stratification for the lowest level ADL scores for the proposed new groups would add needless complexity and, thus, would not be warranted. Instead, we propose to combine that level with the next higher level, and would no longer use the ADL scores lower than 7. Thus, the proposed new groups would be stratified only by two levels of ADL score. For example, the Rehabilitation High plus Extensive Services group would be subdivided into only two ADL levels, ADL scores of 7-12 and 13-18. This left us with only one level for Rehabilitation Low plus Extensive Services and with only two levels at each of the other sub-categories in the new category, for a total of 9 new groups. As a result, we are proposing the addition of 9 new RUG-III groups.

Table 3a
Crosswalk Between Existing RUG-III Rehabilitation Groups and the Proposed Extensive Plus Rehabilitation Groups

	Current Rehabilitation Groups	New Combined Extensive Plus Rehabilitation Groups
Rehab Ultra	• RUC ADL 16 – 18 • RUB – ADL 9 – 15 • RUA – ADL 4 – 8	• RUX – ADL 16 - 18 • RUL – ADL 7 - 15
Rehab Very High	• RVC – ADL 16 – 18 • RVB – ADL 9 – 15 • RVA – ADL 4 – 8	• RVX – ADL 16 – 18 • RVL – ADL 7 - 15
Rehab High	• RHC – ADL 13 – 18 • RHB – ADL 8 – 12 • RHA – ADL 4 – 7	• RUX – ADL 13 - 18 • RUL – ADL 7 - 12
Rehab Medium	• RHC – ADL 15 - 18 • RHB – ADL 8 - 14 • RHA – ADL 4 - 7	• RUX – ADL 15 – 18 • RUL – ADL 7 – 14
Rehab Low	• RLB – ADL 14 – 18 • RLA – ADL 4 - 13	• RUX – ADL 7 - 18

c. Development of the Case-Mix Indexes

We developed the case-mix indexes for the proposed refined RUG-III system using the same method used for calculating the initial SNF PPS case-mix indexes. The original staff time studies conducted in 1990, 1995, and 1997 resulted in the assignment of resident-specific and non-resident specific time (minutes) to individual SNF residents. In the initial determination of the case-mix indexes, the residents were classified into the 44-group system and the minutes of staff time, nursing, and therapy services, where appropriate, remained associated with those

residents. All of the staff time was stratified by type of staff providing the minutes of time (for example, RN, LPN, etc.), and the minutes were weighted for salary.

In order to calculate weights for the proposed refined system, we used the minutes as originally assigned at the individual patient level. We reclassified the patients into the proposed 53 groups with their associated wage-weighted minutes of resident-specific and nonresident-specific staff time. The next step was to apply these wage-weighted minutes to the entire sample population of 26 million days. We multiplied the population in each group by the wage-weighted minutes for each of the staff types. We then derived an average for the group using the sum of the wage-weighted minutes for all staff (nursing and therapy staff minutes were calculated separately) divided by the total population for that group. The relative weight was then calculated by dividing that average by the average minutes across all of the RUG-III groups.

The nursing weights changed more than the therapy weights, due to the redistribution of patients from existing groups to the newly created proposed groups. Even though many of the beneficiaries who move into one of the proposed new groups are from an existing therapy group, the therapy weights are affected only slightly. This is

because the amount of therapy time does not change significantly between the existing groups and the proposed new groups. The therapy groups were already narrowly stratified by minutes of therapy provided. The groups' weights would be affected only to the extent that the individual beneficiaries who are reclassified into one of the proposed new groups have unusually high or low minutes of therapy within the specific limits. The nursing weights are more affected by the reclassifications, as those are based on a much broader scope of possible minute values.

The therapy weights for the nine proposed Rehabilitation Therapy plus Extensive Services groups were identical to those for the comparable existing RUG-III rehabilitation therapy groups. Although we are capturing increased medical/clinical complexity with the proposed new groups, the therapy contribution remains the same as for the existing therapy groups. In this way, the Rehabilitation High therapy weight is identical to the new Rehabilitation High plus Extensive Services sub-category.

The effect of the increased number of groups and changes in the case-mix indexes should be distributional. By this we mean that the relative weights assigned to each RUG-III group would shift so that the proposed new Rehabilitation plus Extensive groups would have the highest

relative weights and the weights for other RUG-III groups would decrease proportionally.

The results of applying these methods to index calculation worked well and yielded hierarchically sound indexes for all of the groups; that is, the indexes for the highest groups in the hierarchy are higher than for those below it, and this pattern holds throughout the proposed new category.

The nursing indexes in the new category, as well as in the existing rehabilitation category, are naturally more compressed (that is, encompass a smaller range) than those in the 44-group RUG-III rehabilitation groups. The groups within the new Rehabilitation plus Extensive category are more homogeneous than were the rehabilitation groups of the 44-group system. By removing the most clinically complex cases and better accounting for them by putting them in rehabilitation groups of their own, both the resulting proposed new category and the remaining rehabilitation category groups would be more homogeneous and, therefore, the relative weights for each set of groups would exhibit less variance.

Next, we simulated payments using the existing weights compared to the new weights to ensure that the refinement did not result in greater or lesser aggregate payments.

The simulation results showed an almost exact match in payments under both case-mix models. However, the proposed new 53-group model did yield a slight decrease (less than 1 percent) in aggregate Medicare payments. To remove this minor variance, we then applied a factor of +.02 to calibrate the nursing indexes and re-ran the simulation. Using this calibration factor of +.02, we are able to ensure absolute parity of aggregate payment under the 53-group RUG-III system compared to the 44-group system.

Finally, we propose to provide for an additional adjustment to the nursing component of the case-mix weights (which includes non-therapy ancillary services) for all RUG-53 groups. As discussed further in section II.B.3 of this proposed rule, we have reviewed data that show a high degree of variability in non-therapy ancillary utilization, not only within but across RUG groups. Therefore, we believe that it is appropriate to adjust the case-mix weights for all 53 groups (that is, the existing 44 RUG-III groups plus the 9 new groups that we are proposing to create in this proposed rule) to better account for non-therapy ancillary variability. We would do this under our authority in section 1888(e)(4)(G)(i) of the Act to establish an “appropriate adjustment to account for case mix . . . .”

In determining the size of this adjustment, we considered not only the high degree of variability in non-therapy ancillary costs, but also the absence of an outlier policy under the SNF PPS. Accordingly, we looked at the outlier pool established under another post-acute care PPS, the one for inpatient rehabilitation facility (IRF) services, which is set at 3 percent of aggregate expenditures. For the purpose of this refinement, our calculations employed a comparable funding level that could be targeted toward payment of non-therapy ancillaries. Based on this analysis, we are proposing an increase to the nursing component of the case-mix weights (the component that includes non-therapy ancillaries) of approximately 8.4 percent, which equates to approximately 3 percent of aggregate expenditures under the SNF PPS. The final RUG-53 nursing indexes are presented in Tables 4a and 5a. Further information regarding this adjustment can be found in section II.B.3 of this proposed rule.

3. Proposed Refinements to the Case-Mix Classification System

[If you choose to comment on issues in this section, please include the caption "Proposed Refinements to the Case-Mix Classification System" at the beginning of your comments.]

We note that, of the various individual refinements that were collectively set forth in the FY 2001 proposed rule (65 FR 19194), the particular refinement that entailed the least amount of added complexity (yet addressed the medically complex patient) involved the creation of several additional groups that would comprise a new, combined Rehabilitation plus Extensive Services category. As we noted in that proposed rule:

> There are . . . a significant number of beneficiaries who would classify into the Extensive Services category based on clinical conditions but who, because they are also receiving rehabilitation services, classify into one of the Rehabilitation groups instead (due to the hierarchical logic of the RUG-III classification system). These beneficiaries carry with them the same non-therapy ancillary costs associated with their complex clinical needs even though they are classified into a RUG-III Rehabilitation category. The high costs for beneficiaries in the Extensive Services category suggest that the payment rate for Extensive Services should be increased. However, increasing the payment rate without further adjustments could adversely affect provider incentives to provide therapy to

beneficiaries requiring Extensive Services.

Therefore, we expanded the scope of the proposed refinement to include new categories for beneficiaries who qualify for both Extensive Services and a RUG-III Rehabilitation category.

Further, as our subsequent research (discussed in the previous section) confirmed, the creation of a proposed new Rehabilitation plus Extensive category would be a means of accounting more accurately for the costs of certain medically complex patients, with the added benefit of a minimal degree of added complexity. We note that, in the past, some support has been expressed for making this particular type of modification to the existing case-mix classification system.

Therefore, we propose to refine the case-mix classification system under section 1888(e)(4)(G)(i) of the Act by creating a new, combined Rehabilitation plus Extensive category, that better accounts for medically complex patients, as required in section 101 of the BBRA. Accordingly, the payment rates set forth in this proposed rule reflect the use of the refined 53-group RUG classification system that we are proposing. The nine groups that we propose to add to the existing RUG-III system are as follows:

RUX Rehabilitation Ultra High plus Extensive Services, High

RUL Rehabilitation Ultra High plus Extensive Services, Low

RVX Rehabilitation Very High plus Extensive Services, High

RVL Rehabilitation Very High plus Extensive Services, Low

RHX Rehabilitation High plus Extensive Services, High

RHL Rehabilitation High plus Extensive Services, Low

RMX Rehabilitation Medium plus Extensive Services, High

RML Rehabilitation Medium plus Extensive Services, Low

RLX Rehabilitation Low plus Extensive Services

We note that, like our current proposal, the case-mix refinement that we considered in our FY 2001 proposed rule would have reconfigured the RUGs themselves, in a general effort to allocate payments more accurately under the SNF PPS. However, that earlier proposal also included an additional element, which was intended to help ensure more accurate allocation of payments specifically with regard to non-therapy ancillaries (such as drugs and medications, laboratory services, supplies and other equipment). For example, it proposed moving the non-therapy ancillary costs used in establishing the nursing case-mix component of the payment rates to a separate, newly created “medical ancillary” component (65 FR 19192, April 10, 2000). In addition, it suggested a number of possible models, both

weighted and unweighted, for a new non-therapy ancillary index (65 FR 19248ff.). As noted in the FY 2001 final rule, these elements ultimately were not adopted when subsequent research indicated that their added complexity would outweigh their increased predictive power (65 FR 46774, July 31, 2000).

Following the publication of that final rule, further research in this area revealed a high degree of variability in non-therapy ancillary utilization, both within and across the various RUG-III groups. This finding suggested that using an index model to address non-therapy ancillary services might require the creation of such a high number of groups as to be impractical.

In fact, the ability of the SNF PPS to account adequately for non-therapy ancillary services has been the subject of attention (and a focus of our research) since the very inception of the system. When the Congress originally enacted the SNF PPS in the BBA, it expressed concern in the accompanying legislative history ". . . that under a prospective payment system that includes all services there may be incentives to decrease the use of ancillary services" (H. Rep. No. 105-149 at 1318). Subsequent legislative initiatives, such as the BBRA mandate to develop case-mix refinements that better account

for “medically complex” patients, and the directive in section 311(d) of the BIPA for the GAO to conduct a study of the adequacy of Medicare’s SNF payment rates, can all be viewed in the context of an ongoing Congressional concern in this area.

For those reasons, and because the data that we have show wide variability in non-therapy ancillary utilization within each RUG, we believe the refinement that we now propose should include not only a reconfiguration of the RUGs that addresses the accuracy of payment allocation in general terms, but also an additional element that improves the accuracy of payment allocation and accounts more directly for cost variations related to non-therapy ancillary services. Accordingly, as part of our proposed refinement, we propose to increase the case-mix indexes of the existing 44 RUG-III groups (as well as those of the nine proposed new Rehabilitation plus Extensive Services RUGs), by calculating a percentage increase that would increase aggregate payments.

As noted previously, we have reviewed data that show great variability in the ancillary services (such as pharmacy) utilized by different SNF residents who are classified into the same RUG-III group. For example, two different patients, both classified into the SE3 group,

might utilize markedly different amounts of ancillary services for reasons that are not captured within the current RUG-III classification methodology. Our data show that the same is true across all of the existing 44 RUG-III groups. The addition of the 9 new groups does not, in itself, compensate for this discrepancy. Although the SNF payment system is designed as a prospective payment system, under which SNFs that treat patients grouped into the same clinical condition should receive the same base payment, the variability in ancillary usage that our data show makes it difficult to account fully for non-therapy ancillary costs by adjusting the number of groups. Therefore, we believe that it is appropriate, considering the data that we have available to us, to provide for an adjustment to each RUG case-mix weight to account for the variability in non-therapy ancillaries, using the authority that we have under section 1888(e)(4)(G)(i) of the Act.

Additionally, we have found a high degree of variability in non-therapy ancillaries not only within but across RUG groups. We have reviewed data showing that an individual patient who is classified into a less intensive RUG may nonetheless be significantly more expensive to treat in terms of non-therapy ancillaries than an individual patient in a more intensive RUG. The data that

we have do not adequately explain these discrepancies, and the addition of the 9 new RUGs does not eliminate them. Our data show that the same is true across all 44 RUG-III groups. We note that in creating the SNF PPS, the Congress enacted the only PPS legislation in the Medicare program that does not establish an outlier policy to capture high variability in resource utilization. Therefore, in view of the data that we have available to us that demonstrates wide disparities in non-therapy ancillary resources consumed by patients both within and across RUG-III groups, we believe that it is appropriate to adjust the case-mix weights for all 53 groups (that is, the existing 44 RUG-III groups plus the 9 new groups that we are proposing to create in this proposed rule) to better account for non-therapy ancillary variability. We would do this by exercising our authority under section 1888(e)(4)(G)(i) of the Act to establish an "appropriate adjustment to account for case mix," in order to maintain access and quality of care for heavy-care patients.

In determining the size of this adjustment, we considered the high degree of variability in non-therapy ancillary costs (which was not yet known at the time that the BBA and the BBRA were enacted), and the absence of an outlier policy under the SNF PPS. Accordingly, we looked

at the outlier pool established under another PPS for post-acute care, the inpatient rehabilitation facility prospective payment system (IRF PPS), which is set at 3 percent of aggregate expenditures. For the purpose of this refinement, we calculated the SNF dollars needed to achieve a comparable funding level that could be targeted towards payment of non-therapy ancillaries. Based on this analysis, we are proposing an increase to the nursing component of the case-mix weights (the component that includes non-therapy ancillaries) of approximately 8.4 percent, which equates to approximately 3 percent of aggregate expenditures under the SNF PPS.

Moreover, we believe that this type of adjustment can essentially serve as a proxy for the non-therapy ancillary index that we proposed previously as a means of achieving more appropriate payment for these services, without the potential drawbacks of our earlier proposal in terms of complexity and addressing variability in utilization. In fact, while we are confident that the decision to maintain a relatively small number of RUG groups is correct in terms of the overall operation of the SNF PPS, it is still true that this number of groups made it extremely difficult to distinguish different levels of non-therapy ancillary use. The problem may be less severe in other PPSs that use a

greater number of groups. For example, the IRF PPS was initially structured to have 100 groups, and the inpatient hospital PPS (IPPS) has over 500 diagnosis-related groups. Similarly, there are over 7,000 relative value units under the resource-based relative value scale that determines the payment rates for physician and other Part B services. By contrast, under this proposed rule, there will be only 53 RUGs. By definition, then, there will be wider variation in the resource needs of patients classified into a particular RUG. We, therefore, believe that it is appropriate to provide for a further adjustment to the case-mix index to compensate for these broad discrepancies.

We note that we are advancing these proposed changes under our authority in section 101(a) of the BBRA to establish case-mix refinements, and that the changes we are hereby proposing will represent the final adjustments made under this authority. Accordingly, any future changes to the case-mix weights or other components of the SNF PPS would be accomplished through staff time measures and other validated analytical studies.

As further explained in section II.B.4 of this proposed rule, these additional payments would partially offset the expiration of the temporary add-on payments that will occur, under the terms of section 101(c) of the BBRA,

upon the implementation of this proposed case-mix refinement. We believe that implementing the proposed case-mix refinement in this manner will carry out Congressional intent that the BBRA's temporary payment add-ons should not continue indefinitely into the future, while at the same time ensuring that payments under the SNF PPS continue to support the quality of care furnished in this setting.

Further, the creation of the proposed new Rehabilitation plus Extensive Services groups underscores the importance of ensuring the accuracy of patient classifications, particularly with regard to those categories, such as Extensive Services, that encompass medically complex patients. One way to accomplish this could be by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example, during the prior qualifying hospital stay). In the July 30, 1999 SNF PPS final rule (64 FR 41668 through 41669), we noted a public comment that questioned the appropriateness of the MDS's 14-day "look-back" provision in the specific context of the SNF level of care presumption. While we made no revisions to the look-back provision at that time, we

specifically reserved the right to reconsider the continued use of this mechanism in the future.

Subsequent analysis in this area has focused on the four items contained in the Special Service section of the MDS (P1a – IV medications, suctioning, tracheostomy care, and use of a ventilator/respirator) that serve to classify residents into Extensive Care, the category used for the most medically complex SNF patients under the RUG-III classification system. This analysis indicates that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) that were furnished exclusively during the period before SNF admission. Depending on how such a proposal was formulated, it has the potential to reduce overall SNF payments by better aligning them with the services actually provided. Therefore, we seek comment on the potential savings and other impacts of revising the MDS Manual instructions to include only those special care treatments and programs (MDS Section P1a) furnished to the resident since admission or re-admission to the SNF, similar to the requirement for P1b. We anticipate that this change can be accomplished through an update to the

MDS Manual instructions, and will not involve system changes at the facility, State agency, or Federal level.

In addition, we are inviting comments on other policy options that could enhance the accuracy of the payment system and improve the quality of care provided to Medicare beneficiaries during an SNF stay, without limiting access to post-acute care. For example, we have received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. We invite comments on this specific recommendation as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments. Another example of a possible policy change on which we invite comment would be whether it might be appropriate to eliminate the projection of anticipated therapy services during the 5-day PPS assessment. We invite comments on these and other existing SNF policies that may have an impact on the quality of care in this setting.

In accordance with section 101 of the BBRA, implementing these proposed refinements to the case-mix system means that the payment rates set forth in this proposed rule would no longer reflect the temporary add-ons to the Federal rates for specified RUG-III groups. We understand that the expiration of the temporary payment

increases, provided for in that legislation, results in a significant reduction in Medicare's payments between FY 2005 and FY 2006. In fact, MedPAC has consistently urged that, until CMS can design a new payment methodology, some or all of the temporary add-on payments be retained and allocated towards beneficiaries with complex medical needs.

While this proposed rule sets forth refinements to the existing case-mix classification system and RUG-III categories, we are soliciting comments on the economic impact of the resulting payment changes, as well as their potential impact on beneficiaries' access to quality SNF care. We also invite comments on possible ways in which the case-mix classification system itself might be further modified to help mitigate the effect of the payment changes.

We note that the expiration of the BBRA add-on payments would not necessarily affect the temporary 128 percent increase in the per diem adjusted payment rates for SNF residents with AIDS. In enacting that temporary increase, the Congress cited past research indicating that ". . . AIDS patients have much higher costs than other patients in the same resource utilization groups in skilled nursing facilities" (H. Rep. No. 108-178, Part 2, at 221).

This underscored the Congress' view that AIDS patients are unique among SNF residents in that they incur significantly higher care costs than residents with other diagnoses, including those who classify to the same RUG-III group. We believe that even if a case-mix refinement can meet the BBRA criterion of better accounting for the needs of medically complex patients generally, this still might not enable the Secretary to certify under section 1888(e)(12)(B) of the Act ". . . that there is an appropriate adjustment in the case mix . . . to compensate for the increased costs" specifically associated with this particular group of patients. Thus, while the implementation of case-mix refinements will trigger the expiration of the 20 percent and 6.7 percent add-on payments under section 101(a) of the BBRA (as amended by section 314 of the BIPA), this may not necessarily be the case for the AIDS add-on payments under section 511 of the MMA. Accordingly, pending further examination of this issue, we believe that it would be premature at this time for the Secretary to make the required certification under section 1888(e)(12)(B) of the Act with respect to the unique conditions that pertain to the care of SNF residents with AIDS. As a result, the 128 percent add-on payments

for SNF residents with AIDS will remain in effect during FY 2006.

The case-mix adjusted payment rates are listed separately for urban and rural SNFs for the existing 44 group RUG and proposed RUG-53 classification systems in Tables 4, 4a, 5, and 5a, with the corresponding case-mix index values.

We also remain committed to our long-term efforts to monitor the RUG-III case-mix classification system and to an ongoing effort to increase the accuracy and efficiency of the SNF PPS. A series of analyses, including the studies used to develop the refinements discussed above, will be discussed in a forthcoming report to the Congress. In this report, we will discuss the findings and put forth a series of next steps that will provide a framework for future progress. In addition, we have posted data describing the research conducted by ABT and the Urban Institute on our SNF PPS website at www.cms.hhs.gov/providers/SNF PPS. Commenters may wish to consult this material to facilitate a more in depth understanding of the proposals contained in this document.

Moreover, we would like to take this opportunity to discuss our thinking related to broader initiatives in this area related to quality of care. Through the Nursing Home

Quality Initiative, the Long Term Care Task Force and other forums for collaborative action, CMS has worked with the SNF industry on the development of valid quality measures, and a variety of quality improvement efforts focused on nursing homes. These efforts and others have resulted in improvements in the quality of care, particularly in facilities that adopt a culture that promotes quality through continuous quality initiatives (CQI), culture change, and other similar programs. Pay for performance is a tool that could provide additional support to improve the quality of care provided in nursing homes. In this way, we could recognize and support the ongoing efforts of nursing homes to improve quality.—

Designing Pay for Performance programs for the SNF setting presents some significant issues. While Medicare beneficiaries are the primary users of SNF services, only a small percentage of these beneficiaries (that is, approximately 10 percent) receive services that are reimbursed under Medicare Part A. The majority of beneficiaries receive services that are reimbursed by multiple payers, including Medicare Part B, Medicaid, and private insurance, and that are delivered within different parts of a nursing facility. Therefore, it is not enough to change practice patterns in just a part of a nursing

home (that is, skilled units), as Medicare beneficiaries can be placed anywhere in the facility. In addition, the focus of the nursing, rehabilitative, and medical interventions will typically vary for persons who are receiving short-term skilled nursing facility services versus those persons who are long-term residents in nursing facilities.

For these reasons, quality measures must be carefully constructed; that is, broad-based and designed to effect change across the mix of patients residing in the facility. Similarly, we need to consider how to design effective incentives; that is, superior performance measured against pre-established benchmarks and/or performance improvements.

In addition, while our efforts to develop the various post-acute care PPSs (including the SNF PPS) have generated substantial improvements over the preexisting cost-based systems, each of these individual systems was developed independently. As a result, we have focused on phases of a patient's illness as defined by a specific site of service, rather than on the entirety of the post-acute episode from the standpoint of the patient rather than the facility. As the various provider types (such as SNFs and inpatient rehabilitation facilities (IRFs)) provide similar types of services in some cases, and as the opportunities to provide

similar services in different settings increase, we need to investigate a more coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode.

This could entail a strategy of developing payment policy that is as neutral as possible regarding provider and patient decisions about the use of particular post-acute services. That is, Medicare should provide payments sufficient to ensure that beneficiaries receive high quality care in the most appropriate setting, so that admissions and any transfers between settings occur only when consistent with good care, rather than to generate additional revenues. In order to accomplish this objective, we need to collect and compare clinical data across different sites of service.

In fact, in the long run, our ability to compare clinical data across care settings is one of the benefits that will be realized as a basic component of our interest in the use of standardized electronic health records (EHRs) and other steps to promote continuity of care across all settings, including nursing homes. It is also important to recognize the complexity of the effort, not only in developing an integrated assessment tool that is designed using health information standards, but in examining the

various provider-centric prospective payment methodologies and considering patient-centric payment approaches that are based on patient characteristics and outcomes. MedPAC has recently taken a preliminary look at the challenges in improving the coordination of our post-acute care payment methods, and suggested that it may be appropriate to explore additional options for reimbursing post-acute services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods, including the SNF PPS.

We also want to encourage incremental changes that will help us build toward these longer-term objectives. For example, several automated medical record tools are now available that could allow hospitals and SNFs to coordinate discharge planning procedures more closely. These tools can be used to ensure communication of a standardized data set that can also be used to establish a comprehensive SNF care plan. Improved communications may reduce the incidence of potentially avoidable re-hospitalizations and other negative effects on quality of care that occur when patients are transferred to SNFs without a full understanding of their care needs. CMS is looking at ways that Medicare providers can use these tools to generate

timely data to support continuity across settings. We are also interested in comments on payment reforms that could promote and reward such continuity, and avoid the medical complications and additional costs associated with re-hospitalization.

Some of the ideas discussed here may exceed CMS's current statutory authority. However, we believe that it is useful to encourage discussion of a broad range of ideas for debate of the relative advantages and disadvantages of the various policies affecting this important component of the health care sector, to ensure that our administrative actions provide maximum support for further steps toward higher quality post-acute care. We welcome comments on these and other approaches.

4. Implementation Issues

[If you choose to comment on issues in this section, please include the caption "Implementation Issues" at the beginning of your comments.]

As noted previously in this proposed rule, the temporary add-on payments enacted by section 101(a) of the BBRA expire upon the implementation of case-mix refinements. Section 101(c) of the BBRA specifies that the actual date on which these temporary add-on payments are to expire is "the later of--(1) October 1, 2000; or (2) the

date on which the Secretary implements a refined case mix classification system under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) to better account for medically complex patients". Section 1888(e)(4)(G)(i) of the Act, in turn, specifies that the Secretary shall provide for an "appropriate adjustment" to account for case mix.

While this proposed rule sets forth proposed updates to the SNF PPS payment rates that are to take effect as of October 1, 2005, we recognize that adopting the proposed refinements to the case-mix classification system will likely entail significant changes for SNFs as well as for Medicare contractors. Therefore, in order to allow sufficient time for preparation and to ease the transition to the proposed refinements, we believe that it would be appropriate under section 1888(e)(4)(G)(i) of the Act to make a case-mix adjustment that reflects the implementation of the refinements described below.

Accordingly, from October 1, 2005, through December 31, 2005, we propose to make payment based entirely on the existing 44-group RUG-III classification system. Beginning on January 1, 2006, we propose to make payment based entirely on the proposed new RUG-53 classification system. This means that under the terms of

section 101(c) of the BBRA, the temporary add-on payments for certain designated RUG-III groups will expire as of January 1, 2006. We note that the resulting reduction in payment will be partially offset by the increase in the RUG case-mix indexes, as explained previously in section II.B.3 of this proposed rule. We invite comments on all aspects of implementing the proposed case-mix refinements, including our plan to defer implementation until January 1, 2006.

Further, along with those matters relating specifically to the case-mix classification system, we have identified a number of broader clinical issues that we are also taking this opportunity to address:

5. Assessment Timeframes

We would like to take this opportunity to clarify existing requirements regarding completion of Other Medicare Required Assessments (OMRAs) for beneficiaries reimbursed under the SNF PPS. An OMRA is due 8 to 10 days after the cessation of all therapy (occupational and physical therapies and speech-language pathology services) in all situations where the beneficiary was assigned a rehabilitation RUG-III group on the previous assessment.

The "last day of therapy" is the last day on which a therapy service was furnished. It is not the day the

discharge order for therapy was received and/or written on the resident's medical record. Therefore, when the last day that therapy was provided falls on a Friday, the Saturday and Sunday directly following are counted as days 1 and 2, respectively, toward the total 8 to 10 days of the OMRA window. The same principles apply when the "midnight rule" is initiated during a beneficiary's Part A SNF stay.

In addition, in the relatively uncommon situations where a resident starts a leave of absence after the therapy services have been discontinued and is out of the facility for part of the 8 to 10 day period during which the OMRA must be completed, those therapeutic leave days are to be counted when determining the OMRA due date. While this information is not new, we determined that it would be beneficial to clarify and remind the public of these specific issues involving the OMRA.

6. SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

[If you choose to comment on issues in this section, please include the caption "SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists" at the beginning of your comments.]

We are taking this opportunity to clarify the requirement for physician signature on the certification and recertification of the need for SNF care (§424.20(e)(2)) as it relates to nurse practitioners (NPs) and clinical nurse specialists (CNSs). In section 6028 of the Omnibus Budget Reconciliation Act of 1989, the Congress amended section 1814(a)(2) of the Act. As amended, the Act specifies that an NP or CNS ". . . who does not have a direct or indirect employment relationship" with the facility but is working in collaboration with a physician may sign the required certification (or recertification) for a beneficiary's SNF stay. (Section 1819(b)(6)(A) of the Act further specifies that the medical care of each SNF resident must be under the supervision of a physician (see also the regulations at 42 CFR 483.40(a)(1)).) This provision that bars NPs and CNSs from having a direct or indirect employment relationship with a SNF in order to sign a certification or recertification of the need for care is very restrictive. By contrast, a similar statutory limitation (see section 1919(b)(6)(A) of the Act) on the delegation of physician tasks in Medicaid nursing facilities only bars NPs, CNSs, and physician assistants (PAs) from performing delegated tasks if they are actually employed by the facility.

Following the enactment of this legislation, we received numerous inquiries asking us to define "direct" and "indirect" employment relationships in greater detail. In the July 26, 1995 final rule (60 FR 38268), we stated that factors indicating whether a NP or CNS has a direct or indirect employment relationship include, but are not limited to the following:

- The facility or someone on its medical staff has the authority to hire or fire the nurse;
- The facility or someone on its medical staff furnishes the equipment or place to work, sets the hours, and pays the nurse by the hour, week, or month;
- The facility or someone on its medical staff restricts the nurse’s ability to work for someone else or provides training and requires the nurse to follow instructions.

We note that the longstanding common law test, as set forth in regulations at 20 CFR 404.1005, 404.1007, and 404.1009, continues to determine the presence of a direct employment relationship for the purposes of this provision. However, numerous inquiries from providers and other stakeholders continue to request that we specifically clarify the definition of an "indirect" employment relationship in those situations where no direct employment relationship

exists. Accordingly, we propose to revise the regulations at §424.20(e)(2) to identify the existence of an indirect employment relationship in terms of the type of services that the practitioner performs in the SNF. We note that NPs and CNSs who are employed by SNFs not only perform the types of delegated physician tasks that are permitted under the long-term care facility requirements for participation at 42 CFR 483.40(e), but typically perform general nursing services as well. We believe that, even in the absence of a direct employment relationship, an SNF that has an NP or CNS perform these general nursing services is essentially utilizing the NP or CNS in the same manner as it would an employee, so that an indirect employment relationship can be considered to exist. Accordingly, in situations where there is no direct employment relationship between the SNF and the NP or CNS, we propose that an indirect employment relationship exists whenever the NP or CNS not only performs delegated physician tasks, but also provides nursing services under the regulations at 42 CFR 409.21, which include such services within the scope of coverage under the Part A SNF benefit. We believe that this criterion is appropriate, because there would be a potential conflict of interest if an NP or CNS who is engaged in furnishing covered Part A nursing services to an

SNF's resident were also permitted to certify as to that resident's need for Part A SNF care. We invite comments on the effects of establishing our proposed distinction in this context.

7. Concurrent Therapy

[If you choose to comment on issues in this section, please include the caption "Concurrent Therapy" at the beginning of your comments.]

The SNF PPS proposed rule for FY 2002 (66 FR 23991, May 10, 2001) included a discussion of concurrent therapy, a practice also known as "dovetailing." In that discussion, we noted that this practice involves a single professional therapist treating more than one Medicare beneficiary at a time--in some cases, many more than one individual at a time. In contrast to group therapy, in which all participants are working on some common skill development, each beneficiary who receives concurrent therapy likely is not receiving services that relate to those needed by any of the other participants. Although the care that each beneficiary receives may be prescribed in his or her individual plan of treatment, it may not conform to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the

complex skill level required for coverage by Medicare. We expressed particular concern over instances in which facility management might inappropriately attempt to increase productivity by coercing a therapist, against his or her own professional judgment, to perform concurrent therapy.

In the SNF PPS final rule for FY 2002 (66 FR 39567, July 31, 2001), we noted that most of the public comments that we received on this discussion urged us to continue to recognize concurrent therapy as skilled therapy, and contended that therapists are treating more than one beneficiary concurrently only when appropriate. However, others indicated that our concerns regarding concurrent therapy were, in fact, warranted. They reported that since the implementation of the SNF PPS, professional therapists are encountering increased pressure to be more productive than they have in the past, including the need to see more than one patient at a time, and performing documentation and collaboration with other members of the care team as non-reimbursed time. In response to the comments, we acknowledged that concurrent therapy can have a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations. However,

while we declined to make any specific policy changes at that time, we reiterated that it is inappropriate for a facility to require, as a condition of employment, that a therapist agree to treat more than one beneficiary at a time in situations where providing treatment in such a manner would compromise the therapist's professional judgment. We also noted that we might revisit this issue in the future should the need to do so arise.

Since that time, we have continued to encounter reports of facilities that attempt to override the therapist’s professional judgment and have concurrent therapy performed in the absence of valid clinical considerations. Accordingly, we believe it is appropriate at this time to consider once again whether there is a need to issue additional guidelines to preclude the inappropriate provision of concurrent therapy. We invite comment on the most effective way to prevent the abuse of this practice, and to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

We propose to establish an effective date of January 1, 2006, as the beginning date for the use of the proposed case-mix refinements. Accordingly, from October 1, 2005, through December 31, 2005, we propose to

make payment based entirely on the existing 44-group RUG-III classification system. Tables 4, 5, 6, and 7 reflect the corresponding rate information for the existing 44 group RUG-III classification system to be used during this time.

Beginning on January 1, 2006, we propose to make payment based on the proposed new RUG-53 classification system (and, thus, would not include the add-on payments). Tables 4a, 5a, 6a, and 7a reflect the corresponding rate information for the proposed RUG-53 classification system.

Tables 4 and 5 reflect the updated SNF Federal rates for FY 2006 for the existing 44 group RUG-III classification system. Tables 4a and 5a reflect the updated SNF Federal rates for FY 2006 for the RUG-53 classification system. The first nine groups listed in the tables are for new Rehabilitation plus Extensive Services groups.

Table 4
RUG-44
Case-Mix Adjusted Federal Rates and Associated Indexes
Urban

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUC	1.30	2.25	178.67	232.94		70.15	481.76

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUB	0.95	2.25	130.57	232.94		70.15	433.66
RUA	0.78	2.25	107.20	232.94		70.15	410.29
RVC	1.13	1.41	155.31	145.98		70.15	371.44
RVB	1.04	1.41	142.94	145.98		70.15	359.07
RVA	0.81	1.41	111.33	145.98		70.15	327.46
RHC	1.26	0.94	173.17	97.32		70.15	340.64
RHB	1.06	0.94	145.69	97.32		70.15	313.16
RHA	0.87	0.94	119.57	97.32		70.15	287.04
RMC	1.35	0.77	185.54	79.72		70.15	335.41
RMB	1.09	0.77	149.81	79.72		70.15	299.68
RMA	0.96	0.77	131.94	79.72		70.15	281.81
RLB	1.11	0.43	152.56	44.52		70.15	267.23
RLA	0.80	0.43	109.95	44.52		70.15	224.62
SE3	1.70		233.65		13.63	70.15	317.43
SE2	1.39		191.04		13.63	70.15	274.82
SE1	1.17		160.80		13.63	70.15	244.58
SSC	1.13		155.31		13.63	70.15	239.09
SSB	1.05		144.31		13.63	70.15	228.09
SSA	1.01		138.81		13.63	70.15	222.59
CC2	1.12		153.93		13.63	70.15	237.71
CC1	0.99		136.07		13.63	70.15	219.85
CB2	0.91		125.07		13.63	70.15	208.85
CB1	0.84		115.45		13.63	70.15	199.23
CA2	0.83		114.08		13.63	70.15	197.86
CA1	0.75		103.08		13.63	70.15	186.86

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
IB2	0.69		94.83		13.63	70.15	178.61
IB1	0.67		92.08		13.63	70.15	175.86
IA2	0.57		78.34		13.63	70.15	162.12
IA1	0.53		72.84		13.63	70.15	156.62
BB2	0.68		93.46		13.63	70.15	177.24
BB1	0.65		89.34		13.63	70.15	173.12
BA2	0.56		76.97		13.63	70.15	160.75
BA1	0.48		65.97		13.63	70.15	149.75
PE2	0.79		108.58		13.63	70.15	192.36
PE1	0.77		105.83		13.63	70.15	189.61
PD2	0.72		98.96		13.63	70.15	182.74
PD1	0.70		96.21		13.63	70.15	179.99
PC2	0.65		89.34		13.63	70.15	173.12
PC1	0.64		87.96		13.63	70.15	171.74
PB2	0.51		70.09		13.63	70.15	153.87
PB1	0.50		68.72		13.63	70.15	152.50
PA2	0.49		67.35		13.63	70.15	151.13
PA1	0.46		63.22		13.63	70.15	147.00

Table 4a
RUG-53
Case-Mix Adjusted Federal Rates and Associated Indexes
Urban

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	1.80	2.24	247.39	231.91		70.15	549.45
RUL	1.33	2.24	182.80	231.91		70.15	484.86
RVX	1.46	1.32	200.66	136.66		70.15	407.47
RVL	1.26	1.32	173.17	136.66		70.15	379.98
RHX	1.34	1.10	184.17	113.88		70.15	368.20
RHL	1.30	1.10	178.67	113.88		70.15	362.70
RMX	1.83	1.03	251.52	106.64		70.15	428.31
RML	1.60	1.03	219.90	106.64		70.15	396.69
RLX	1.25	0.79	171.80	81.79		70.15	323.74
RUC	1.21	2.24	166.30	231.91		70.15	468.36
RUB	0.94	2.24	129.19	231.91		70.15	431.25
RUA	0.79	2.24	108.58	231.91		70.15	410.64
RVC	1.16	1.32	159.43	136.66		70.15	366.24
RVB	1.02	1.32	140.19	136.66		70.15	347.00
RVA	0.79	1.32	108.58	136.66		70.15	315.39
RHC	1.15	1.10	158.06	113.88		70.15	342.09
RHB	1.05	1.10	144.31	113.88		70.15	328.34
RHA	0.89	1.10	122.32	113.88		70.15	306.35
RMC	1.09	1.03	149.81	106.64		70.15	326.60
RMB	1.02	1.03	140.19	106.64		70.15	316.98
RMA	0.99	1.03	136.07	106.64		70.15	312.86
RLB	1.08	0.79	148.44	81.79		70.15	300.38

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RLA	0.80	0.79	109.95	81.79		70.15	261.89
SE3	1.76		241.89		13.63	70.15	325.67
SE2	1.41		193.79		13.63	70.15	277.57
SE1	1.19		163.55		13.63	70.15	247.33
SSC	1.16		159.43		13.63	70.15	243.21
SSB	1.07		147.06		13.63	70.15	230.84
SSA	1.03		141.56		13.63	70.15	225.34
CC2	1.15		158.06		13.63	70.15	241.84
CC1	1.01		138.81		13.63	70.15	222.59
CB2	0.93		127.82		13.63	70.15	211.60
CB1	0.86		118.20		13.63	70.15	201.98
CA2	0.85		116.82		13.63	70.15	200.60
CA1	0.77		105.83		13.63	70.15	189.61
IB2	0.70		96.21		13.63	70.15	179.99
IB1	0.68		93.46		13.63	70.15	177.24
IA2	0.59		81.09		13.63	70.15	164.87
IA1	0.54		74.22		13.63	70.15	158.00
BB2	0.69		94.83		13.63	70.15	178.61
BB1	0.66		90.71		13.63	70.15	174.49
BA2	0.57		78.34		13.63	70.15	162.12
BA1	0.49		67.35		13.63	70.15	151.13
PE2	0.80		109.95		13.63	70.15	193.73
PE1	0.78		107.20		13.63	70.15	190.98
PD2	0.74		101.71		13.63	70.15	185.49
PD1	0.72		98.96		13.63	70.15	182.74

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
PC2	0.67		92.08		13.63	70.15	175.86
PC1	0.65		89.34		13.63	70.15	173.12
PB2	0.52		71.47		13.63	70.15	155.25
PB1	0.51		70.09		13.63	70.15	153.87
PA2	0.50		68.72		13.63	70.15	152.50
PA1	0.48		65.97		13.63	70.15	149.75

Table 5
RUG-44
Case-Mix Adjusted Federal Rates and Associated Indexes
Rural

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUC	1.30	2.25	170.69	268.61		71.45	510.75
RUB	0.95	2.25	124.74	268.61		71.45	464.80
RUA	0.78	2.25	102.41	268.61		71.45	442.47
RVC	1.13	1.41	148.37	168.33		71.45	388.15
RVB	1.04	1.41	136.55	168.33		71.45	376.33
RVA	0.81	1.41	106.35	168.33		71.45	346.13
RHC	1.26	0.94	165.44	112.22		71.45	349.11
RHB	1.06	0.94	139.18	112.22		71.45	322.85
RHA	0.87	0.94	114.23	112.22		71.45	297.90
RMC	1.35	0.77	177.26	91.92		71.45	340.63
RMB	1.09	0.77	143.12	91.92		71.45	306.49
RMA	0.96	0.77	126.05	91.92		71.45	289.42
RLB	1.11	0.43	145.74	51.33		71.45	268.52

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RLA	0.80	0.43	105.04	51.33		71.45	227.82
SE3	1.70		223.21		14.56	71.45	309.22
SE2	1.39		182.51		14.56	71.45	268.52
SE1	1.17		153.62		14.56	71.45	239.63
SSC	1.13		148.37		14.56	71.45	234.38
SSB	1.05		137.87		14.56	71.45	223.88
SSA	1.01		132.61		14.56	71.45	218.62
CC2	1.12		147.06		14.56	71.45	233.07
CC1	0.99		129.99		14.56	71.45	216.00
CB2	0.91		119.48		14.56	71.45	205.49
CB1	0.84		110.29		14.56	71.45	196.30
CA2	0.83		108.98		14.56	71.45	194.99
CA1	0.75		98.48		14.56	71.45	184.49
IB2	0.69		90.60		14.56	71.45	176.61
IB1	0.67		87.97		14.56	71.45	173.98
IA2	0.57		74.84		14.56	71.45	160.85
IA1	0.53		69.59		14.56	71.45	155.60
BB2	0.68		89.28		14.56	71.45	175.29
BB1	0.65		85.35		14.56	71.45	171.36
BA2	0.56		73.53		14.56	71.45	159.54
BA1	0.48		63.02		14.56	71.45	149.03
PE2	0.79		103.73		14.56	71.45	189.74
PE1	0.77		101.10		14.56	71.45	187.11
PD2	0.72		94.54		14.56	71.45	180.55
PD1	0.70		91.91		14.56	71.45	177.92

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
PC2	0.65		85.35		14.56	71.45	171.36
PC1	0.64		84.03		14.56	71.45	170.04
PB2	0.51		66.96		14.56	71.45	152.97
PB1	0.50		65.65		14.56	71.45	151.66
PA2	0.49		64.34		14.56	71.45	150.35
PA1	0.46		60.40		14.56	71.45	146.41

Table 5a
RUG-53
Case-Mix Adjusted Federal Rates and Associated Indexes
Rural

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	1.8	2.24	236.34	267.41		71.45	575.20
RUL	1.33	2.24	174.63	267.41		71.45	513.49
RVX	1.46	1.32	191.70	157.58		71.45	420.73
RVL	1.26	1.32	165.44	157.58		71.45	394.47
RHX	1.34	1.10	175.94	131.32		71.45	378.71
RHL	1.3	1.10	170.69	131.32		71.45	373.46
RMX	1.83	1.03	240.28	122.96		71.45	434.69
RML	1.6	1.03	210.08	122.96		71.45	404.49
RLX	1.25	0.79	164.13	94.31		71.45	329.89
RUC	1.21	2.24	158.87	267.41		71.45	497.73
RUB	0.94	2.24	123.42	267.41		71.45	462.28
RUA	0.79	2.24	103.73	267.41		71.45	442.59
RVC	1.16	1.32	152.31	157.58		71.45	381.34

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RVB	1.02	1.32	133.93	157.58		71.45	362.96
RVA	0.79	1.32	103.73	157.58		71.45	332.76
RHC	1.15	1.10	151.00	131.32		71.45	353.77
RHB	1.05	1.10	137.87	131.32		71.45	340.64
RHA	0.89	1.10	116.86	131.32		71.45	319.63
RMC	1.09	1.03	143.12	122.96		71.45	337.53
RMB	1.02	1.03	133.93	122.96		71.45	328.34
RMA	0.99	1.03	129.99	122.96		71.45	324.40
RLB	1.08	0.79	141.80	94.31		71.45	307.56
RLA	0.80	0.79	105.04	94.31		71.45	270.80
SE3	1.76		231.09		14.56	71.45	317.10
SE2	1.41		185.13		14.56	71.45	271.14
SE1	1.19		156.25		14.56	71.45	242.26
SSC	1.16		152.31		14.56	71.45	238.32
SSB	1.07		140.49		14.56	71.45	226.50
SSA	1.03		135.24		14.56	71.45	221.25
CC2	1.15		151.00		14.56	71.45	237.01
CC1	1.01		132.61		14.56	71.45	218.62
CB2	0.93		122.11		14.56	71.45	208.12
CB1	0.86		112.92		14.56	71.45	198.93
CA2	0.85		111.61		14.56	71.45	197.62
CA1	0.77		101.10		14.56	71.45	187.11
IB2	0.70		91.91		14.56	71.45	177.92
IB1	0.68		89.28		14.56	71.45	175.29
IA2	0.59		77.47		14.56	71.45	163.48

RUG-53 Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
IA1	0.54		70.90		14.56	71.45	156.91
BB2	0.69		90.60		14.56	71.45	176.61
BB1	0.66		86.66		14.56	71.45	172.67
BA2	0.57		74.84		14.56	71.45	160.85
BA1	0.49		64.34		14.56	71.45	150.35
PE2	0.80		105.04		14.56	71.45	191.05
PE1	0.78		102.41		14.56	71.45	188.42
PD2	0.74		97.16		14.56	71.45	183.17
PD1	0.72		94.54		14.56	71.45	180.55
PC2	0.67		87.97		14.56	71.45	173.98
PC1	0.65		85.35		14.56	71.45	171.36
PB2	0.52		68.28		14.56	71.45	154.29
PB1	0.51		66.96		14.56	71.45	152.97
PA2	0.50		65.65		14.56	71.45	151.66
PA1	0.48		63.02		14.56	71.45	149.03

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that we find appropriate. Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. We propose to continue that practice for FY 2006, as we continue to believe that in the absence of SNF-specific wage data, using the hospital wage index is appropriate and reasonable for the SNF PPS.

The wage index adjustment would be applied to the proposed labor-related portion of the Federal rate, which is 76.087 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2006. The labor-related relative importance is calculated from the SNF market basket, and approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2006. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost

share weights for FY 2006 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2006 in four steps. First, we compute the FY 2006 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2006 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2006 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we sum the FY 2006 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, nonmedical professional fees, labor-intensive services, and capital-related expenses) to produce the FY 2006 labor-related relative importance. Tables 6 and 7 show the Federal rates by labor-related and non-labor-related components for the existing 44 group RUG classification system. Tables 6a and 7a show the Federal rates by labor-related and non-labor-related components for the proposed RUG-53 classification system.

Table 6
RUG-44
Case-Mix Adjusted Federal Rates for Urban SNFs
By Labor and Non-Labor Component

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
RUC	481.76	366.56	115.20
RUB	433.66	329.96	103.70
RUA	410.29	312.18	98.11
RVC	371.44	282.62	88.82
RVB	359.07	273.21	85.86
RVA	327.46	249.15	78.31
RHC	340.64	259.18	81.46
RHB	313.16	238.27	74.89
RHA	287.04	218.40	68.64
RMC	335.41	255.20	80.21
RMB	299.68	228.02	71.66
RMA	281.81	214.42	67.39
RLB	267.23	203.33	63.90
RLA	224.62	170.91	53.71
SE3	317.43	241.52	75.91
SE2	274.82	209.10	65.72
SE1	244.58	186.09	58.49
SSC	239.09	181.92	57.17
SSB	228.09	173.55	54.54
SSA	222.59	169.36	53.23
CC2	237.71	180.87	56.84
CC1	219.85	167.28	52.57
CB2	208.85	158.91	49.94
CB1	199.23	151.59	47.64
CA2	197.86	150.55	47.31
CA1	186.86	142.18	44.68
IB2	178.61	135.90	42.71
IB1	175.86	133.81	42.05
IA2	162.12	123.35	38.77
IA1	156.62	119.17	37.45
BB2	177.24	134.86	42.38
BB1	173.12	131.72	41.40
BA2	160.75	122.31	38.44
BA1	149.75	113.94	35.81
PE2	192.36	146.36	46.00
PE1	189.61	144.27	45.34
PD2	182.74	139.04	43.70
PD1	179.99	136.95	43.04
PC2	173.12	131.72	41.40
PC1	171.74	130.67	41.07
PB2	153.87	117.08	36.79

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
PB1	152.50	116.03	36.47
PA2	151.13	114.99	36.14
PA1	147.00	111.85	35.15

Table 6a
RUG-53
Case-Mix Adjusted Federal Rates for Urban SNFs
By Labor and Non-Labor Component

RUG-53 Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	549.45	418.06	131.39
RUL	484.86	368.92	115.94
RVX	407.47	310.03	97.44
RVL	379.98	289.12	90.86
RHX	368.20	280.15	88.05
RHL	362.70	275.97	86.73
RMX	428.31	325.89	102.42
RML	396.69	301.83	94.86
RLX	323.74	246.32	77.42
RUC	468.36	356.36	112.00
RUB	431.25	328.13	103.12
RUA	410.64	312.44	98.20
RVC	366.24	278.66	87.58
RVB	347.00	264.02	82.98
RVA	315.39	239.97	75.42
RHC	342.09	260.29	81.80
RHB	328.34	249.82	78.52
RHA	306.35	233.09	73.26
RMC	326.60	248.50	78.10
RMB	316.98	241.18	75.80
RMA	312.86	238.05	74.81
RLB	300.38	228.55	71.83
RLA	261.89	199.26	62.63
SE3	325.67	247.79	77.88
SE2	277.57	211.19	66.38
SE1	247.33	188.19	59.14
SSC	243.21	185.05	58.16
SSB	230.84	175.64	55.20
SSA	225.34	171.45	53.89
CC2	241.84	184.01	57.83
CC1	222.59	169.36	53.23
CB2	211.60	161.00	50.60
CB1	201.98	153.68	48.30
CA2	200.60	152.63	47.97
CA1	189.61	144.27	45.34

RUG-53 Category	Total Rate	Labor Portion	Non-Labor Portion
IB2	179.99	136.95	43.04
IB1	177.24	134.86	42.38
IA2	164.87	125.44	39.43
IA1	158.00	120.22	37.78
BB2	178.61	135.90	42.71
BB1	174.49	132.76	41.73
BA2	162.12	123.35	38.77
BA1	151.13	114.99	36.14
PE2	193.73	147.40	46.33
PE1	190.98	145.31	45.67
PD2	185.49	141.13	44.36
PD1	182.74	139.04	43.70
PC2	175.86	133.81	42.05
PC1	173.12	131.72	41.40
PB2	155.25	118.13	37.12
PB1	153.87	117.08	36.79
PA2	152.50	116.03	36.47
PA1	149.75	113.94	35.81

Table 7
RUG-44
Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
RUC	510.75	388.61	122.14
RUB	464.80	353.65	111.15
RUA	442.47	336.66	105.81
RVC	388.15	295.33	92.82
RVB	376.33	286.34	89.99
RVA	346.13	263.36	82.77
RHC	349.11	265.63	83.48
RHB	322.85	245.65	77.20
RHA	297.90	226.66	71.24
RMC	340.63	259.18	81.45
RMB	306.49	233.20	73.29
RMA	289.42	220.21	69.21
RLB	268.52	204.31	64.21
RLA	227.82	173.34	54.48
SE3	309.22	235.28	73.94
SE2	268.52	204.31	64.21
SE1	239.63	182.33	57.30
SSC	234.38	178.33	56.05
SSB	223.88	170.34	53.54
SSA	218.62	166.34	52.28

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
CC2	233.07	177.34	55.73
CC1	216.00	164.35	51.65
CB2	205.49	156.35	49.14
CB1	196.30	149.36	46.94
CA2	194.99	148.36	46.63
CA1	184.49	140.37	44.12
IB2	176.61	134.38	42.23
IB1	173.98	132.38	41.60
IA2	160.85	122.39	38.46
IA1	155.60	118.39	37.21
BB2	175.29	133.37	41.92
BB1	171.36	130.38	40.98
BA2	159.54	121.39	38.15
BA1	149.03	113.39	35.64
PE2	189.74	144.37	45.37
PE1	187.11	142.37	44.74
PD2	180.55	137.38	43.17
PD1	177.92	135.37	42.55
PC2	171.36	130.38	40.98
PC1	170.04	129.38	40.66
PB2	152.97	116.39	36.58
PB1	151.66	115.39	36.27
PA2	150.35	114.40	35.95
PA1	146.41	111.40	35.01

Table 7a
RUG-53
Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG-53 Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	575.20	437.65	137.55
RUL	513.49	390.70	122.79
RVX	420.73	320.12	100.61
RVL	394.47	300.14	94.33
RHX	378.71	288.15	90.56
RHL	373.46	284.15	89.31
RMX	434.69	330.74	103.95
RML	404.49	307.76	96.73
RLX	329.89	251.00	78.89
RUC	497.73	378.71	119.02
RUB	462.28	351.73	110.55
RUA	442.59	336.75	105.84
RVC	381.34	290.15	91.19
RVB	362.96	276.17	86.79

RUG-53 Category	Total Rate	Labor Portion	Non-Labor Portion
RVA	332.76	253.19	79.57
RHC	353.77	269.17	84.60
RHB	340.64	259.18	81.46
RHA	319.63	243.20	76.43
RMC	337.53	256.82	80.71
RMB	328.34	249.82	78.52
RMA	324.40	246.83	77.57
RLB	307.56	234.01	73.55
RLA	270.80	206.04	64.76
SE3	317.10	241.27	75.83
SE2	271.14	206.30	64.84
SE1	242.26	184.33	57.93
SSC	238.32	181.33	56.99
SSB	226.50	172.34	54.16
SSA	221.25	168.34	52.91
CC2	237.01	180.33	56.68
CC1	218.62	166.34	52.28
CB2	208.12	158.35	49.77
CB1	198.93	151.36	47.57
CA2	197.62	150.36	47.26
CA1	187.11	142.37	44.74
IB2	177.92	135.37	42.55
IB1	175.29	133.37	41.92
IA2	163.48	124.39	39.09
IA1	156.91	119.39	37.52
BB2	176.61	134.38	42.23
BB1	172.67	131.38	41.29
BA2	160.85	122.39	38.46
BA1	150.35	114.40	35.95
PE2	191.05	145.36	45.69
PE1	188.42	143.36	45.06
PD2	183.17	139.37	43.80
PD1	180.55	137.38	43.17
PC2	173.98	132.38	41.60
PC1	171.36	130.38	40.98
PB2	154.29	117.39	36.90
PB1	152.97	116.39	36.58
PA2	151.66	115.39	36.27
PA1	149.03	113.39	35.64

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments that are greater or lesser

than would otherwise be made in the absence of the wage adjustment. For FY 2006 (Federal rates effective October 1, 2005), we would apply the most recent wage index using the hospital wage data, and apply an adjustment to fulfill the budget neutrality requirement. This requirement would be met by multiplying each of the components of the unadjusted Federal rates by a factor equal to the ratio of the volume weighted mean wage adjustment factor (using the wage index from the previous year) to the volume weighted mean wage adjustment factor, using the wage index for the FY beginning October 1, 2005. The same volume weights are used in both the numerator and denominator and will be derived from 1997 Medicare Provider Analysis and Review File (MEDPAR) data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share. The proposed budget neutrality factor for this year is 1.0011. However, this may change in the final rule. In order to give the public a sense of the magnitude of this adjustment, last year's factor was 1.0011.

D. Proposed Area Wage Index

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area

wage levels, using a wage index that we find appropriate. Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. As noted previously, we are proposing to continue that practice for FY 2006.

In our July 30, 2004 update notice, we acknowledged that on June 6, 2003, the Office of Management and Budget (OMB) issued "OMB Bulletin No.03-04," which announced revised definitions for Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the Bulletin may be obtained at the following Internet address: http://www.whitehouse.gov/omb/bulletins/b03-04.html. At that time, we did not propose to apply these new definitions known as the Core-Based Statistical Areas (CBSAs). After further analysis, we are proposing to use the OMB-revised definitions to adjust the FY 2006 SNF PPS payment rates. The Hospital Inpatient PPS (IPPS) is applying these revised definitions as discussed in the August 11, 2004 IPPS final rule (69 FR 49207).

1. Proposed Revision of SNF PPS Geographic Classifications

As discussed in the May 12, 1998 SNF PPS interim final rule, which implemented the SNF PPS (63 FR 26252), in

establishing an adjustment for area wage levels under §413.337(a)(ii), the labor-related portion of a SNF's Federal prospective payment is adjusted by using an appropriate wage index. As set forth in §413.337(a)(ii), a SNF's wage index is determined based on the location of the SNF in an urban or rural area as defined in §412.62(f)(1)(ii) and (f)(1)(iii), respectively. In general, an urban area is defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) as defined by OMB. Under §412.62(f)(1)(iii), a rural area is defined as any area outside of an urban area. The urban and rural area geographic classifications defined in §412.62(f)(1)(ii) and (f)(1)(iii), respectively, were used under the IPPS from FYs 1985 through 2004 (§412.63(b)), and have been used under the SNF PPS since it was implemented for cost reporting periods beginning on or after July 1, 1998. The wage index used for the SNF PPS is calculated using the IPPS wage index data on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The applicable SNF wage index value is assigned to a SNF on the basis of the labor market area in which the SNF is geographically located.

Section 4410 of the BBA provides that for the purposes of section 1886(d)(3)(E) of the Act, the area wage index applicable to hospitals located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in the State. Consistent with past SNF policy, we treat this provision, commonly referred to as the "rural floor," as applicable to acute inpatient hospitals and not SNFs. Therefore, the hospital wage index used for SNFs is commonly referred to as "pre-floor," indicating that the "rural floor" provision is not applied.

The current SNF PPS labor market areas are defined based on the definitions of MSAs, Primary MSAs (PMSAs), and NECMAs issued by the OMB (commonly referred to collectively as "MSAs"). These MSA definitions, which are discussed in greater detail below, are currently used under the SNF PPS and other prospective payment systems such as the long-term care hospital PPS (LTCH PPS), the inpatient psychiatric facility PPS (IPF PPS), the home health agency PPS (HHA PPS), and the inpatient rehabilitation facility PPS (IRF PPS). In the August 11, 2004 IPPS final rule (67 FR 49026 through 49034), revised labor market area definitions were adopted under §412.64(b), which were effective October 1, 2004 for acute care hospitals. The new

standards, CBSAs, were announced by OMB in late 2000 and are discussed in greater detail below.

2. Current SNF PPS Labor Market Areas Based on MSAs

As noted above, we currently define labor market areas based on the definitions of MSAs, PMSAs, and NECMAs issued by the OMB. The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

These different designations use counties as the building blocks upon which they are based. Therefore, providers are assigned to either an MSA, PMSA, or NECMA based on whether the county in which the provider is located is part of that area. All of the counties in a State outside a designated MSA, PMSA, or NECMA are designated as rural. For the purposes of calculating the wage index, we combine all of the counties in a State outside a designated MSA, PMSA, or NECMA together to calculate the statewide rural wage index for each State.

3. Core-Based Statistical Areas

The OMB reviews its Metropolitan Area (MA) definitions preceding each decennial census. As discussed in the August 11, 2004 IPPS final rule (69 FR 49207), in the fall of 1998, the OMB chartered the Metropolitan Area Standards Review Committee to examine the MA standards and develop recommendations for possible changes to those standards. Three notices related to the review of the standards, providing an opportunity for public comment on the recommendations of the Committee, were published in the **Federal Register** on the following dates: December 21, 1998 (63 FR 70526); October 20, 1999 (64 FR 56628); and August 22, 2000 (65 FR 51060).

In the December 27, 2000 **Federal Register** (65 FR 82228 through 82238), the OMB announced its new standards. In that notice, the OMB defines a Core-Based Statistical Area (CBSA), beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." The standards designate and define two categories of CBSAs: MSAs and Micropolitan Statistical Areas (65 FR 82235).

According to the OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan

Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters of at least 10,000 population, but less than 50,000 population. Counties that do not fall within CBSAs (either MSAs or Micropolitan Areas) are deemed "Outside CBSAs." In the past, the OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were "Outside MSAs." On June 6, 2003, the OMB announced the new CBSAs, comprised of MSAs and the new Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html.)

The new CBSA designations recognize 49 new (urban) MSAs and 565 new Micropolitan Areas, and revise the composition of many of the existing (urban) MSAs. There are 1,090 counties in MSAs under the new CBSA designations (previously, there were 848 counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were before the change in designations, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer

designated to either an MSA or a new Micropolitan Area: Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA. For a more detailed discussion of the conceptual basis of the new CBSAs, refer to the August 11, 2004 IPPS final rule (67 FR 49026 through 49034).

4. Proposed Revisions to the SNF PPS Labor Market Areas

[If you choose to comment on issues in this section, please include the caption "Proposed Revisions to the SNF PPS Labor Market Areas" at the beginning of your comments.]

In its June 6, 2003 announcement, the OMB cautioned that these new definitions "should not be used to develop and implement Federal, State, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas."

In the SNF PPS update notice for FY 2005 (69 FR 45786, July 30, 2004), we noted that the recently-published IPPS proposed rule for FY 2005 had discussed some of the problems and concerns associated with using these new definitions, and had invited public comment on them.

Accordingly, we decided to defer proposing any new labor market definitions in the SNF context at that time, in order to allow the public sufficient time and opportunity to consider and provide comments on this issue. Although the June 30, 2004 update notice also invited comments on the possible application of the new definitions to the SNF PPS, we received no written comments on the use of the new definitions specifically in the SNF context; however, we did receive a few phone calls inquiring about the methodology applied in the August 11, 2004 IPPS final rule (69 FR 49207). We believe that sufficient time has now elapsed for interested parties to consider and react to the new OMB definitions and, accordingly, we are now proposing to make the changes discussed below.

We have continued to use MSAs to define labor market areas for purposes of the wage index. For the SNF prospective payment system, the statute provides the Secretary with broad authority to use an "appropriate wage index as determined by the Secretary." We believe MSAs are a reasonable and appropriate proxy for developing geographic areas for purposes of adjusting for wage differences in SNF PPS and for many of the same reasons stated in the various IPPS rules over the years where this issue has been exhaustively examined. We also note that

MSAs are used to define labor market areas for purposes of the wage index for many of the other Medicare payment systems (for example, IRF PPS, HHA PPS, and IPF PPS).

First, historically, Medicare prospective payment systems have utilized MA definitions developed by OMB. For example, in discussing the adoption of the MSA designation for the IPPS area labor adjustment, the IPPS proposed rule for FY 1985 (49 FR 27426, July 3, 1984) stated:

> [i]n administering a national payment system, we must have a national classification system built on clear, objective standards. Otherwise the program becomes increasingly difficult to administer because the distinction between rural and urban hospitals is blurred. We believe that the MSA system is the only one that currently meets the requirements for use as a classification system in a national payment program. The MSA classification system is a statistical standard developed for use by Federal agencies in the production, analysis, and publication of data on metropolitan areas. The standards have been developed with the aim of producing definitions that will be as consistent as possible for all MSAs nationwide.

In addition, in numerous instances, the Congress has recognized that the areas developed by OMB may be used for

differentiating among geographic areas for Medicare payment purposes. For example, in the IPPS statutory sections, the Congress defines an "urban area" as "an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized" (section 1886(d)(2)(D) of the Act). Similarly, in the sections of the statute governing the guidelines to be used by the Medicare Geographic Classification Review Board for purposes of reclassification, the Congress directed the Secretary to create guidelines for "determining whether the county in which the hospital is located should be treated as being a part of a particular [MSA]" (sections 1886(d)(10)(A) and 1886(d)(10)(D)(i)(II) of the Act). Thus, the Congress has accepted and ratified the use of MSAs as an inherently rational manner of dividing up labor-market areas for purposes of Medicare payments.

The process used by OMB to develop the MSAs creates geographic areas based upon characteristics that we believe also generally reflect the characteristics of unified labor market areas. For example, the CBSAs reflect a core population plus an adjacent territory that reflects a high degree of social and economic integration. This integration is measured by commuting ties, thus

demonstrating that these areas may draw workers from the same general areas. In addition, the most recent CBSAs reflect the most up to date information. The OMB reviews its MA definitions preceding each decennial census to reflect recent population changes, and the CBSAs are based on the Census 2000 data. Finally, in the context of the IPPS, CMS has reviewed alternative methods for determining geographic areas for purposes of the wage index, and in each case, has decided to retain the OMB designations rather than replace these designations with alternatives.

Because we believe that we have broad authority to create labor market areas, and because we also believe that the OMB's latest MA designations accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, we are proposing to adopt the revised labor market area designations based on the OMB's CBSA designations.

When we implemented the wage index adjustment at §413.337(a)(ii) under the SNF PPS in the May 12, 1998 SNF PPS interim final rule (63 FR 26252), we explained that the SNF PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Because we believe that the OMB’s CBSA designations

based on Census 2000 data reflect the most recent available geographic classifications (MA definitions), we are proposing to revise the labor market area definitions used under the SNF PPS. Specifically, we are proposing to revise the SNF PPS labor market definitions based on the OMB's new CBSA designations (as discussed in greater detail below) effective for SNF PPS services occurring on or after October 1, 2005. Accordingly, we are proposing to revise §413.337(a)(ii) to specify that for services furnished on or after October 1, 2005, the application of the wage index under the SNF PPS would be made on the basis of the location of the facility in an urban or rural area as defined in §412.64(b)(1)(ii)(A) through (C).

We note that the OMB's new CBSA designations are the same labor market area definitions implemented under the IPPS at §412.64(b), which were effective for those hospitals beginning October 1, 2004, as discussed in the August 11, 2004 IPPS final rule (69 FR 49026 through 49034). The similarity between the IPPS and the SNF PPS includes the adoption in the initial implementation of the SNF PPS of the same labor market area definitions under the SNF PPS that existed under the IPPS at that time, as well as the use of acute care hospitals' wage data in calculating the SNF PPS wage index. Therefore, we believe

that proposing to revise the SNF PPS labor market area definitions based on OMB's CBSA designations is consistent with our historical practice of generally modeling SNF PPS wage index policy after IPPS wage index policy.

Below, we discuss the composition of the proposed SNF PPS labor market areas based on the OMB's new CBSA designations.

a. New England MSAs

As stated above, under the SNF PPS, we currently use NECMAs to define labor market areas in New England, because these are county-based designations rather than the 1990 MSA definitions for New England, which used minor civil divisions such as cities and towns. Under the current MSA definitions, NECMAs provided more consistency in labor market definitions for New England compared with the rest of the country, where MSAs are county-based. Under the new CBSAs, the OMB has now defined the MSAs and Micropolitan Areas in New England on the basis of counties. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs.

In order to create consistency among all labor market areas and to maintain these areas on the basis of counties, we are proposing to use the county-based areas for all MSAs in the nation, including those in New England. Census 2000

has now defined the New England area based on counties, creating a city- and town-based system as an alternative. We believe that adopting county-based labor market areas for the entire country except those in New England would lead to inconsistencies in our designations. Adopting county-based labor market areas for the entire country provides consistency and stability in Medicare SNF PPS program payment because all of the labor market areas throughout the country, including New England, would be defined using the same system (that is, counties) rather than different systems in different areas of the country, thus minimizing programmatic complexity.

In addition, we have consistently employed a county-based system for New England for precisely that reason: to maintain consistency with the labor market definitions used throughout the country. We note that this is consistent with the implementation of the CBSA designations under the IPPS for New England (see August 11, 2004 (69 FR 49028)). Accordingly, under the SNF PPS we are proposing to use the New England MSAs as determined under the proposed new CBSA-based labor market area definitions in defining the proposed revised SNF PPS labor market areas.

b. Metropolitan Divisions

Under the OMB's new CBSA designations, a Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties. A county qualifies as a main county if 65 percent or more of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75 percent. A county qualifies as a secondary county if 50 percent or more, but less than 65 percent, of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75 percent. After all the main and secondary counties are identified and grouped, each additional county that already has qualified for inclusion in the MSA falls within the Metropolitan Division associated with the main/secondary county or counties with which the county at issue has the highest employment interchange measure. Counties in a Metropolitan Division must be contiguous (see 65 FR 82236).

As noted above, in the past, the OMB designated CMSAs as Metropolitan Areas with a population of one million or more and comprised of two or more PMSAs. Under the SNF

PPS, we currently use the PMSAs rather than CMSAs to define labor market areas because they comprise a smaller geographic area with potentially varying labor costs due to different local economies. We believe that CMSAs may be too large an area to reflect accurately the local labor costs of all of the individual SNFs included in that relatively "large" area. Similarly, we believe that Metropolitan Divisions under the CBSA designations may be too large an area to reflect accurately the local labor costs of all of the individual SNFs included in that relatively "large" area. Further, Metropolitan Divisions represent the closest approximation to PMSAs and, therefore, would most accurately maintain our current structuring of the SNF PPS labor market areas. Therefore, as implemented under the IPPS (69 FR 49029), we are proposing to use the Metropolitan Divisions where applicable (as described below) under the proposed new CBSA-based labor market area definitions.

In addition to being comparable to the organization of the labor market areas under current MSA designations, we believe that proposing to use Metropolitan Divisions where applicable (as described below) under the SNF PPS would result in a more accurate adjustment for the variation in local labor market areas for SNFs. Specifically, if we

recognize the relatively "larger" CBSA that comprises two or more Metropolitan Divisions as an independent labor market area for purposes of the wage index, it would be too large and would include the data from too many hospitals to compute a wage index that would accurately reflect the various local labor costs of all of the individual hospitals included in that relatively "large" CBSA. By proposing to recognize Metropolitan Divisions where applicable (as described below) under the proposed new CBSA-based labor market area definitions under the SNF PPS, we believe that the local labor costs would be more accurately reflected, thereby resulting in a wage index adjustment that better reflects the variation in the local labor costs of the local economies of the SNFs located in those relatively "smaller" areas.

Under the CBSA designations, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. Although these MSAs were also CMSAs under the prior definitions, in some cases their areas have been altered. Under the current SNF PPS MSA designations, Boston was a single NECMA. Under the proposed CBSA-based labor market area designations, it would be comprised of 4 Metropolitan

Divisions. Los Angeles would go from 4 PMSAs under the current SNF PPS MSA designations to 2 Metropolitan Divisions under the proposed CBSA-based labor market area designations. The New York CMSA would go from 15 PMSAs under the current SNF PPS MSA designations to only 4 Metropolitan Divisions under the proposed CBSA-based labor market area designations. Five PMSAs in Connecticut under the current SNF PPS MSA designations would become separate MSAs under the proposed CBSA-based labor market area designations. The number of PMSAs in New Jersey, under the current SNF PPS MSA designations would go from 5 to 2, with the consolidation of 2 New Jersey PMSAs (Bergen-Passaic and Jersey City) into the New York-Wayne-White Plains, NY-NJ Division, under the proposed CBSA-based labor market area designations. In San Francisco, under the proposed CBSA-based labor market area designations there are only 2 Divisions. Currently, there are 6 PMSAs, some of which are now separate MSAs under the current SNF PPS labor market area designations.

Under the current SNF PPS labor market area designations, Cincinnati, Cleveland, Denver, Houston, Milwaukee, Portland, Sacramento, and San Juan are all designated as CMSAs, but would no longer be designated as CMSAs under the proposed CBSA-based labor market area

designations. As noted previously, the population threshold to be designated a CMSA under the current SNF PPS labor market area designations is one million. In most of these cases, counties currently in a PMSA would become a separate, independent MSA under the proposed CBSA-based labor market area designations, leaving only the MSA for the core area under the proposed CBSA-based labor market area designations.

c. Micropolitan Areas

Under the OMB's new CBSA designations, Micropolitan Areas are essentially a third area definition consisting primarily of areas that are currently rural, but also include some or all of areas that are currently designated as urban MSAs. As discussed in greater detail in the August 11, 2004 IPPS final rule (69 FR 49029 through 49032), how these areas are treated would have significant impacts on the calculation and application of the wage index. Specifically, whether or not Micropolitan Areas are included as part of the respective statewide rural wage indexes would affect the value of the Statewide rural wage index of any State that contains a Micropolitan Area. A hospital's classification as urban or rural affects which hospitals' wage data are included in the statewide rural wage index. As discussed above in section II.D.3, we

combine all of the counties in a State outside a designated urban area to calculate the statewide rural wage index for each State.

Micropolitan Areas included as part of the statewide rural labor market area would result in an increase to the statewide rural wage index because hospitals located in those Micropolitan Areas typically have higher labor costs than other rural hospitals in the State. Alternatively, as discussed in greater detail below, if Micropolitan Areas would be recognized as independent labor market areas, because there would be so few hospitals in those areas to complete a wage index, the wage indexes for SNFs in those areas could become relatively unstable as they would change considerably from year to year.

We currently use MSAs to define urban labor market areas and group all of the hospitals in counties within each State that are not assigned to an MSA into a statewide rural labor market area. Therefore, we used the terms "urban" and "rural" wage indexes in the past for ease of reference. However, the introduction of Micropolitan Areas by the OMB potentially complicates this terminology because these areas include many hospitals that are currently included in the statewide rural labor market areas.

We are proposing to treat Micropolitan Areas as rural labor market areas under the SNF PPS for the reasons outlined below. That is, counties that are assigned to a Micropolitan area under the CBSA designations would be treated the same as other "rural" counties that are not assigned to either an MSA (Metropolitan Area) or a Micropolitan Area. Therefore, in determining an SNF's applicable wage index (based on IPPS hospital wage index data, as discussed in greater detail below in section II.D.6 of this preamble), we propose that a SNF in a Micropolitan Area under the OMB's CBSA designations would be classified as "rural" and would be assigned the statewide rural wage index for the State in which it resides.

In the August 11, 2004 IPPS final rule (69 FR 49029 through 49032), we discussed the impact of treating Micropolitan areas as part of the statewide rural labor market area instead of treating Micropolitan Areas as independent labor market areas for hospitals paid under the IPPS. As discussed in greater detail in that same final rule, Micropolitan Areas encompass smaller populations than MSAs and tend to include fewer hospitals per Micropolitan Area.

Thus, since Micropolitan Areas tend to include fewer hospitals, recognizing Micropolitan Areas as independent labor market areas would generally increase the potential for dramatic shifts in those areas' wage indexes from one year to the next, because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of the area. Dramatic shifts in an area's wage index from year to year are problematic and create instability in the payment levels from year to year, which could make fiscal planning for SNFs difficult if we adopted this approach. Therefore, in order to minimize the potential instability in payment levels from year to year, we believe it would be appropriate to treat Micropolitan Areas as part of the statewide rural labor market area under the SNF PPS.

Consistent with the treatment of these areas under the IPPS, we are proposing that Micropolitan Areas be considered a part of the Statewide rural labor market area. Accordingly, we are proposing that the SNF PPS Statewide rural wage index would be determined using acute-care IPPS hospital wage data from hospitals located in non-MSA areas and that the Statewide rural wage index would be assigned to SNFs located in those areas.

When the revised labor market areas based on the OMB's new CBSA designations were adopted under the IPPS beginning

on October 1, 2004, a transition to the new designations was established due to the scope and magnitude of the change, in order to mitigate the resulting adverse impact on certain hospitals. As discussed in the August 11, 2004 IPPS final rule (69 FR 49032), during FY 2005, a blend of wage indexes is calculated for those acute care IPPS hospitals experiencing a drop in their wage indexes because of the adoption of the new labor market areas. Also, as described in that same final rule (69 FR 49032), under the IPPS, hospitals that previously had been located in an urban MSA but became rural under the new CBSA definitions are assigned the wage index value of the urban area to which they belonged previously, for 3 years (FYs 2005 through FYs 2007).

We recognize that SNFs will be subject to the same impact as hospitals, and that some SNFs may experience decreases in their wage index as a result of the proposed labor market area changes. At the same time, a significant number of SNFs will benefit from these proposed changes. However, as explained below, we are not proposing a transition period in this proposed rule.

5. Implementation of the Revised Labor Market Areas

Under section 1888(e)(4)(G)(ii) of the Act, the Secretary has the authority to adjust for geographic

variations in labor costs by using an appropriate wage index. Moreover, the adjustment must be made in a manner such that aggregate payments would not change if such adjustment were not made.

To facilitate an understanding of the proposed policies related to the proposed change to the SNF PPS labor market areas discussed above, in Table A (MSA/CBSA Crosswalk) of the Addendum of this proposed rule, we are providing a listing of each Social Security Administration (SSA) State and county location code; State and county name; existing MSA-based labor market area designation; MSA-based wage index value; CBSA-based labor market area; and the new CBSA-based wage index value.

When the revised labor market areas based on OMB's new CBSA designations were adopted under the IPPS beginning on October 1, 2004, a transition to the new designations was established due to the scope and fiscal impact of these new boundaries. As discussed in the IPPS final rule (69 FR 49032), during FY 2005, a blend of wage indexes is calculated for those acute care IPPS hospitals experiencing a drop in their wage indexes because of the adoption of the new labor market areas. The most significant impacts will generally be for MSA-based urban hospitals that were designated as rural under the CBSA-based designations.

Because the former MSA-based labor market areas used under the IPPS had been used for payment for over 10 years, we believed it was necessary to provide additional protection, given the scope and potentially significant implications (and the subsequent adverse impact) of these new labor market areas on numerous acute-care hospitals. Therefore, we implemented a transition under the IPPS from the former MSA-based labor market area designation to the new CBSA-based labor market area designation for acute-care hospitals that would receive a lower wage index as a result of the change in the labor market area designations.

As we recognize that SNFs may experience similar changes in their wage indexes as a result of the proposed labor market area changes, we carefully evaluated the impact of the conversion to the proposed wage index structure. During our analysis, we found that a majority of SNFs (61 percent) either maintained the same wage index or would get an increased wage index based on CBSA definitions. Only a very small number of SNFs (4 percent) would experience a decline of 5 percent or more in the wage index based on CBSA designations. We also found that only a very small number of SNFs would experience a change in either rural or urban designation under the CBSA based definitions. Furthermore, we believe the new CBSA

definitions may have a positive impact on many counties. For example, most counties which had been included in the rural definitions under the MSA designations but are now designated as urban areas under CBSAs will generally receive an increase in their wage index.

Although a majority of SNFs would not be significantly affected, and we believe that it is not appropriate or necessary to propose a transition to the proposed new CBSA-based labor market areas for the purpose of the SNF PPS wage index, we recognize that there are many options in efficiently implementing the new CBSA geographic designations. Thus, we considered several budget neutral options that would most effectively implement the adoption of the proposed CBSA designations as discussed below.

One option we considered institutes a one-year transition with a blended wage index for all providers. The wage index for each provider would consist of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both based on the FY 2002 hospital wage data). However, we found that while this would help some SNFs that would be adversely affected by the proposed changes to the MSAs, it would also reduce the wage index values (compared to fully adopting the CBSA wage index value) for those SNFs that would be

positively affected by the changes. In addition, the budget neutrality factor calculated based on the blended wage index for all SNFs would slightly reduce the unadjusted payment rate for all providers.

A second option we considered was a one-year transition with a blended wage index limited to providers that would experience a decrease due solely to the changes in the labor market definitions. Providers that experience a decrease in their FY 2006 wage index under the CBSA-based definitions compared to the wage index they would have received under the MSA-based definitions (in both cases using FY 2002 hospital wage data) would receive a blended wage index. The wage index for these providers would consist of a blend of 50 percent of the FY 2006 MSA wage index and 50 percent of the FY 2006 CBSA wage index (both based on the FY 2002 hospital wage data). Providers that would experience a decrease due to changes in the labor market definitions would receive the full FY 2006 CBSA wage index.

When we performed our analysis, we found that the unadjusted payment amounts decreased substantially more under this option than they did either by using the first option discussed above or by fully adopting the CBSA designations. As with the first option, the positive

impact of blending in order to decrease the impacts for a relatively small number of SNFs would require reduced payment rates for all providers, including the SNFs receiving a blended wage index.

We also recognize that during FY 2005, as discussed in the August 11, 2004 IPPS final rule (69 FR 49032), a hold harmless policy under IPPS was implemented to minimize the overall impact on hospitals that are currently designated as urban under the MSA designations, but would become rural under the CBSA designations. We considered adopting a hold harmless policy for SNFs, to allow facilities that are currently urban under the MSA definitions (but become rural under the CBSA definitions) to maintain their urban status under the CBSA definitions for one year. However, our analysis shows that only an extremely small number of SNFs would qualify for such a hold harmless policy. As any adjustment requires payments to be made in a budget neutral manner, all providers would have the payment rates reduced for the benefit of that small number of SNFs (1.4 percent) which lose their urban designations. Accordingly, we do not believe it is appropriate or necessary to adopt a hold harmless policy under the SNF PPS for facilities that will experience a change in designation under the CBSA definitions.

We are proposing to adopt for the SNF PPS the new CBSA-based labor market area definitions beginning with the 2006 SNF PPS rate year without a transition period and without a hold harmless policy. We also note that OMB in the past has announced MSA changes on an annual basis due to population changes and we have not transitioned these changes under the SNF PPS.

As noted previously, our data analysis shows that a minimal number of SNFs would experience a decrease of more than 5 percent in the wage index. In addition, under the CBSA designation, an even smaller number of SNFs would experience a change from their current urban or rural designation. Therefore, the aggregate impact on SNFs under the MSA-based designations as compared to the CBSA-based designations does not result in a dramatic change overall.

As explained above, we believe that it is not appropriate or necessary to propose a transition to the proposed new CBSA-based labor market area for the SNF PPS wage index adjustment. In addition, as noted above, we believe the data suggest that the potential benefit of a hold harmless policy for an extremely small number of providers would be outweighed by the resulting decrease in payment rates for all providers. However, we specifically

invite public comments on our proposed approach, as well as on the various transition options discussed above.

Finally, we note that section 505 of the MMA established new section 1886(d)(13) of the Act. The new section 1886(d)(13) requires that the Secretary establish a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. We believe that this requirement for an "out-commuting" or "out-migration" adjustment applies specifically to the Hospital Inpatient Prospective Payment System. Therefore, we will not be establishing such an adjustment for the SNF PPS.

6. Wage Index Data

[If you choose to comment on issues in this section, please include the caption "Wage Index Data" at the beginning of your comments.]

In the FY 2005 SNF PPS update notice (69 FR 45775, July 30, 2004), we established SNF PPS wage index values for the 2005 SNF PPS rate year calculated from the same data (generated in cost reporting periods beginning during FY 2001) used to compute the FY 2005 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act and without applying the "rural

floor" under section 4410 of the BBA. We subsequently published correction notices to update the wage index values. The SNF wage index values applicable for services furnished on or after October 1, 2004 through August 31, 2005 are shown in Table 8 (for urban areas) and Table 9 (for rural areas) in the December 30, 2004 correction notice (69 FR 78445).

Acute care hospital inpatient wage index data is also used to establish the wage index adjustment used in the LTCH PPS, IPF PPS, HHA PPS, and IRF PPS. As we discussed in the May 12, 1998 SNF PPS interim final rule (63 FR 26252), as hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report, and because we would need to establish instructions for the collection of these SNF data in order to establish a geographic reclassification adjustment under the SNF PPS, the wage adjustment established under the SNF PPS is based on a SNF’s actual location without regard to the urban or rural designation of any related or affiliated provider.

In this proposed rule, for the FY 2006 SNF PPS rate year, we propose to use acute care hospital inpatient wage index data generated from cost reporting periods beginning during FY 2002 (without taking into account geographic

reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act and without applying the "rural floor" under section 4410 of the BBA) to determine the applicable wage index values under the SNF PPS, because these data (FY 2002) are the most recent complete data. We realize that there has been some interest in developing a SNF-specific wage index. However, considering the impact of converting to the new OMB classification methodology discussed above, we believe a second major change would be inappropriate at this time. In making this decision, one of our primary concerns is that the combined effect of changing both the wage area categories and the actual wage index could result in an inaccurate impact assessment for one or both of these changes. As discussed in several of the previous SNF PPS rules, we also remain concerned about the potential volatility and unreliability of unaudited data (see, for example, the final rule for FY 2002 (66 FR 39579 through 39596, July 31, 2001), and the final rule for FY 2004 (68 FR 46045 through 46046, August 3, 2003)).

We are proposing to adopt OMB's new labor market designations for CY 2006, effective January 1, 2006. In adopting the CBSA designations, we identified some geographic areas where there were no hospitals, and thus no

hospital wage index data on which to base the calculation of the FY 2006 SNF PPS proposed wage index. In addressing this situation, we are proposing approaches that we believe serve as proxies for hospital wage data and would provide an appropriate standard that accounts for geographic variation in labor costs.

The first situation involves rural locations in Massachusetts and Puerto Rico. Under these labor market areas, there are no rural hospitals in those locations. Because there is no reasonable proxy for more recent rural data within those areas, we are proposing to use last year's wage index value for rural Massachusetts and rural Puerto Rico.

The second situation has to do with the urban areas of Hinesville, GA (CBSA 25980) and Mansfield, OH (CBSA 31900). Again, under the proposed new labor market areas there are no urban hospitals within those areas. We propose to use all of the urban areas within the State to serve as a reasonable proxy for the urban areas without specific hospital wage index data in determining the SNF PPS wage index. Therefore, in this proposed rule, we calculated the urban wage index value for purposes of the wage index for these areas without urban hospital data as the average wage index for all urban areas within the State. We note that

we could not apply a similar averaging in rural areas, because in the rural areas there are no State rural hospital wage data available for averaging on a State-wide basis. We solicit comments on these approaches to calculating the wage index values for areas without hospitals for FY 2006 and subsequent years.

The proposed wage index values that would be applicable for SNF PPS services furnished on or after October 1, 2005 through August 31, 2006 are shown in Tables 8 and 9 in the Addendum of this proposed rule.

E. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act and section 311 of the BIPA, the proposed payment rates listed here reflect a proposed update equal to the full SNF market basket, estimated at 3.0 percentage points. We will continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before August 1 preceding the start of each succeeding fiscal year. We discuss the Federal rate update factor in greater detail in section III.C of this preamble.

F. Relationship of RUG-III Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria

As discussed in §413.345, we include in each update of the Federal payment rates in the **Federal Register** the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in §409.30. This designation reflects an administrative presumption under the current 44-group RUG-III classification system. Our presumption is that any beneficiary who is correctly assigned to one of the upper 26 RUG-III groups in the initial 5-day, Medicare-required assessment is automatically classified as meeting the SNF level of care definition up to the assessment reference date for that assessment.

Any beneficiary assigned to any of the lower 18 groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 26 groups during the immediate post-hospital period require a covered level of care, which would be significantly less likely for those beneficiaries assigned to one of the lower 18 groups.

As discussed in section II.B of this preamble, we propose to refine the existing 44-group RUG-III classification system by adding an additional 9 groups, comprising a new Rehabilitation plus Extensive Services category. In effect, the groups in this new category would encompass care that is at least as intensive as that identified by any of the upper 26 RUG-III groups under the original, 44-group RUG-III classification system. Accordingly, for purposes of the administrative presumption, we propose to designate the upper 35 groups of the proposed 53-group refined case-mix classification system (including the upper 26 groups that we have identified as representing a covered level of care under the existing 44-group system, plus the additional 9 groups

set forth in this proposed rule), consisting of the following RUG classifications: all groups within the proposed new Rehabilitation plus Extensive Services category; all groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; all groups within the Special Care category; and, all groups within the Clinically Complex category.

G. Initial 3-Year Transition Period from Facility Specific to Federal Rates

As noted previously in section I.A and section I.F.2 of this proposed rule, the PPS is no longer operating under the initial 3-year transition period from facility-specific to Federal rates. Therefore, payment now equals the adjusted Federal per diem rate.

H. Example of Computation of Adjusted PPS Rates and SNF Payment

As explained in section II.B of this proposed rule, from October 1, 2005, through December 31, 2005, we propose to make payment based entirely on the existing 44-group RUG-III classification system (including any associated

add-on payments). Using the model SNF (XYZ) described in Table 10, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS for the time period mentioned above using the existing 44 group RUG-III classification system.

Table 10
RUG-44
SNF XYZ: Located in State College, PA
Wage Index: 0.8364

RUG Group	Labor	Wage index	Adj. labor	Non-Labor	Adj. Rate	Percent adjustment	Medi-care Days	Payment
RVC	$282.62	0.8364	$236.38	$88.82	$325.20	$346.99*	14	$ 4,858
RHA	$218.40	0.8364	$182.67	$68.64	$251.31	$268.15*	16	$ 4,290
CC2	$180.87	0.8364	$151.28	$56.84	$208.12	$474.51**	10	$ 4,745
SE3	$241.52	0.8364	$202.01	$75.91	$277.92	$333.50***	30	$10,005
IA2	$123.35	0.8364	$103.17	$38.77	$141.94	$141.94	30	$ 4,258
						Total	100	$28,156

*Reflects a 6.7 percent adjustment from section 314 of the BIPA.

**Reflects a 128 percent adjustment from section 511 of the MMA. Section 101(a) of the BBRA no longer applies because of the MMA section 511 adjustment.

***Reflects a 20 percent adjustment from section 101(a) of the BBRA.

Beginning January 1, 2006, we propose to make payment based on the proposed new RUG-53 classification system (and, thus, would not include the add-on payments). Table 10a shows an example of the actual per diem PPS payments under the RUG-53 classification system.

Table 10a
RUG-53
SNF XYZ: Located in State College, PA
Wage Index: 0.8364

RUG Group	Labor	Wage index	Adj. labor	Non-Labor	Adj. rate	Percent adjustment	Medi-care Days	Pay-ment
RVX	$310.03	0.8364	$259.31	$97.44	$356.75	$356.75	14	$ 4,994
RHA	$233.09	0.8364	$194.96	$73.26	$268.22	$268.22	16	$ 4,291
CC2	$184.01	0.8364	$153.91	$57.83	$211.74	$482.76*	10	$ 4,828
RLX	$246.32	0.8364	$206.02	$77.42	$283.44	$283.44	30	$ 8,503
IA2	$125.44	0.8364	$104.92	$39.43	$144.35	$144.35	30	$ 4,330
						Total	100	$26,946

*Reflects a 128 percent adjustment from section 511 of the MMA.

III. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index) that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. This proposed rule incorporates the latest available projections of the SNF market basket index. The final rule will incorporate updated projections based on the latest available projections at that time. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the July 31, 2001 **Federal Register** (66 FR 39562), we included a complete discussion on the rebasing of the SNF

market basket to FY 1997. There are 21 separate cost categories and respective price proxies. These cost categories were illustrated in Table 10.A, Table 10.B, and Appendix A, along with other relevant information, in the July 31, 2001 **Federal Register**.

Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Table 11 summarizes the proposed updated labor-related share for FY 2006.

Table 11 – FY 2006 Labor-Related Share

	Relative importance, labor-related, **FY 2005** (97 index)	Relative importance, labor-related, **FY 2006** (97 index)
Wages and salaries	54.720	54.572
Employee benefits	11.595	11.691
Nonmedical professional fees	2.688	2.702
Labor-intensive services	4.125	4.116
Capital-related	3.094	3.006
Total	76.222	76.087

A. Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index, as described in the previous section, from the average index level of the prior fiscal year to the average index level of the current fiscal year. For the Federal rates established in this proposed rule, this percentage increase in the SNF market basket index

would be used to compute the update factor occurring between FY 2005 and FY 2006. We used the Global Insight, Inc. (formerly DRI-WEFA), 1st quarter 2005 forecasted percentage increase in the FY 1997-based SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factor. Finally, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the 3-year transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

As discussed in the June 10, 2003, supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46067), the regulations at §413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment applied to the update of the FY 2003 rate that occurred in FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available fiscal year for which there are final data, and are applied whenever the difference between the forecasted and actual

change in the market basket exceeds a 0.25 percentage point threshold. As discussed previously in section I.G of this proposed rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2004 (the most recently available fiscal year for which there are final data) did not exceed the 0.25 percentage point threshold, the payment rates for FY 2006 do not include a forecast error adjustment.

C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2006 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2004 through September 30, 2005 to the average market basket level for the period of October 1, 2005 through September 30, 2006. Using this process, the proposed update factor for FY 2006 SNF Federal rates is 3.0 percentage points. We used this revised proposed update factor to compute the proposed Federal portion of the SNF PPS rate shown in Tables 2 and 3.

IV. Consolidated Billing

As established by section 4432(b) of the BBA, the consolidated billing requirement places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Section 103 of the BBRA amended this provision by further excluding a number of high-cost, low probability services (identified by Healthcare Common Procedure Coding System (HCPCS) codes) within several broader categories that otherwise remained subject to the provision. Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.)

Further, while the services of rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) generally are subject to SNF consolidated billing, section 410 of the MMA provided that when an RHC or FQHC furnishes the services of a physician (or another type of service that section 1888(e)(2)(A)(ii) of the Act

identifies as being excluded from SNF consolidated billing), those services do not become subject to consolidated billing merely by virtue of being furnished under the auspices of the RHC or FQHC. In effect, this provision (which applies to services furnished on or after January 1, 2005) enables those services to retain their separate identity as excluded "practitioner" services in this context, rather than being treated as bundled "RHC" or "FQHC" services. As such, these services would remain separately billable to Part B when furnished to a resident of the SNF during a covered Part A stay.

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as we noted in the proposed rule of April 10, 2000 (65 FR 19232), section 1888(e)(2)(A)(iii) of the Act, as added by section 103 of the BBRA, not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but " . . . also gives the Secretary the authority to designate additional, individual services for exclusion within each of the specified service categories." In that proposed rule, we also noted that the BBRA Conference

report (H.R. Conf. Rep. No. 106-479 at 854) characterizes the individual services that this legislation targets for exclusion as ". . . high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system . . . ." According to the conferees, section 103(a) "is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs . . . ." By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule of July 31, 2000 (65 FR 46790), any additional service codes that we might designate for exclusion under our discretionary authority must meet the same criteria that the Congress used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: they must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability in the SNF setting. Accordingly, we characterized this statutory

authority to identify additional service codes for exclusion " . . . as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice)" (65 FR 46791). In view of the amount of time that has elapsed since we last invited comments on this issue, we believe it is appropriate at this point once again to invite public comments that identify codes in any of these four service categories representing recent medical advances that might meet the BBRA criteria for exclusion from SNF consolidated billing.

We note that the original BBRA legislation (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (for example July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize a Program Memorandum as the vehicle for accomplishing routine updates of the excluded codes, in order to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, for any new services that

would actually represent a substantive change in the scope of services that are excluded from the SNF consolidated billing provision, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, October 1, 2005). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

V. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals

In accordance with section 1888(e)(7) of the Act (as amended by section 203 of the BIPA), Part A pays critical access hospitals (CAHs) on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, as noted previously in section I.A of this notice, the services furnished by non-CAH rural hospitals are paid under the SNF PPS. In the July 31, 2001 final rule (66 FR 39562), we announced the conversion of swing-bed rural hospitals to the SNF PPS, effective with the start of the provider's first cost reporting period beginning on or after July 1, 2002. We selected this date consistent with the statutory provision to integrate swing-bed rural

hospitals into the SNF PPS by the end of the SNF transition period, June 30, 2002.

As of June 30, 2003, all swing-bed rural hospitals have come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this notice for SNF PPS also apply to all swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (Raven-SB for Swing Beds) can be found in the July 31, 2001 final rule (66 FR 39562). The latest changes in the MDS for swing-bed rural hospitals are listed on our SNF PPS web site, www.cms.hhs.gov/providers/snfpps/default.asp.

VI. Qualifying Three-Day Inpatient Hospital Stay Requirement

As indicated in section I.A of this proposed rule, the SNF benefit includes not only level of care requirements, but also a set of technical, or "posthospital" eligibility requirements as well. These requirements date back to the original Medicare legislation (section 102(a) of the Social Security Amendments of 1965, Pub. L. 89-97), when the Congress defined the intended scope of this benefit. The SNF benefit was never intended to cover long-term, relatively low-level "custodial" care; rather, the Congress envisioned this benefit more narrowly, in terms of serving

as a less expensive alternative to what would otherwise be the final, convalescent portion of an acute care stay of several days as an inpatient at a hospital. In order to target the SNF benefit more effectively at the limited segment of the nursing home population that the benefit was actually designed to cover (that is, those beneficiaries requiring a short-term, fairly intensive stay in a SNF as a continuation of an acute hospital stay of several days), the Congress established as a prerequisite for SNF coverage a requirement that a beneficiary must first be a hospital inpatient for "not less than 3 consecutive days before his discharge from the hospital" (section 1861(i) of the Act). From the very inception of the Medicare program, in determining the three-day inpatient requirement for purposes of triggering the SNF benefit, "inpatient" status has been determined as commencing with "the calendar day of admission" to the hospital (see 20 CFR §405.120 (1966)). The current guidelines in the CMS Internet Online Manual (IOM) at Publication 100-02 (Medicare Benefit Policy Manual), Chapter 8 (Coverage of Extended Care (SNF) Services Under Hospital Insurance), §20.1 (Three-Day Prior Hospitalization) reflect this determination.

More recently, it has been suggested that because of changes in hospital admission practices that have occurred

since the Congress enacted this provision in 1965, some patients who at that time would have been a hospital inpatient for at least 3 days are instead now placed in observation status initially, before being formally admitted as a hospital inpatient. Observation status is a distinct service that is discussed in the IOM in Publication 100-02 (Medicare Benefit Policy Manual), Chapter 6 (Hospital Services Covered Under Part B), §70.4 (Outpatient Observation Services), in which a patient who needs more care than can be provided in an emergency room is moved from the emergency room, placed in a hospital bed in the appropriate hospital unit, and monitored by the unit nursing and physician staff. We recognize that coverage of observation services under the outpatient prospective payment system is connected to patients with three specific diagnoses: chest pain, asthma, and congestive heart failure.

However, as we noted previously, the longstanding policy interpretation of the SNF benefit's prior hospital stay requirement does not count hospital observation time that immediately precedes an inpatient admission toward meeting the requirement. We have received occasional inquiries about the effect of this policy on those beneficiaries who would be able to satisfy the SNF

benefit's 3-day hospital stay requirement only if time spent in observation status immediately prior to the formal inpatient admission were counted. These inquiries assert that in such situations, the care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission, so that the beneficiaries themselves often learn of the difference only after they were transferred to the SNF and failed to meet the SNF benefit's prior hospital stay requirement. The inquirers argue that it is unfair to deny SNF coverage to such a beneficiary based solely on what they characterize as a mere recordkeeping convention on the part of the hospital rather than a substantive change in the actual care that the beneficiary receives there.

We note that the current SNF benefit policy (which counts only time following the formal inpatient admission to the hospital toward meeting the qualifying hospital stay requirement) is based directly on the applicable portion of the Medicare law at section 1861(i) of the Act, which defines the SNF benefit’s qualifying hospital stay as one in which the beneficiary ". . . was an <u>inpatient</u> for not less than 3 consecutive days . . " (emphasis added). An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient

hospital services as defined in section 1861 of the Act. Moreover, although at the time that this provision was enacted, the concept of observation status itself was not yet even envisioned, to date, the Congress has not chosen to amend section 1861(i) of the Act specifically to reflect use of observation time as triggering the SNF benefit. However, we are aware that over time, practice and treatment of observation time may have changed; thus, the effect of not counting this observation time under the existing policy ultimately might be to restrict SNF coverage to a narrower segment of the beneficiary population than the Congress originally intended.

Accordingly, with regard to those beneficiaries whose formal admission to the hospital as an inpatient is immediately preceded by time spent in hospital observation status, we invite comments on whether we should consider the possibility of counting the time spent in observation status toward meeting the SNF benefit's qualifying 3-day hospital stay requirement. We note that in evaluating the potential impact of such a change, it is necessary not only to consider its effect on those beneficiaries who might not otherwise be able to meet the SNF benefit's prior qualifying hospital stay requirement, but also to assess potential negative consequences. Possible examples could

include altering the nature of the SNF benefit in a manner that is inconsistent with Congressional intent in establishing this requirement, or creating a "woodwork effect" of unanticipated consequences, such as routine placement of patients in observation status prior to formal admission, even in situations where observation is not appropriate.

In soliciting these comments, moreover, we wish to distinguish the possible use of observation time from time spent in the hospital's emergency room. Although both observation services and emergency room services are directed at patients who are expected to spend only a short period of time in that service area, they are in many other ways dissimilar. Other than for patients with scheduled admissions, the emergency room generally serves as the hospital’s overall point of entry, irrespective of the degree of severity of a particular patient’s condition; thus, many hospital patients typically would commence their hospital encounter by spending at least some time initially in the emergency room. However, the time in the emergency room is not considered a substitute for or equivalent to inpatient hospital care. Clearly, many visits to the ER are for treatment of problems requiring no inpatient hospitalization (for example, most wounds, broken or

sprained limbs, or minor respiratory illnesses) and often patients come to the ER because their regular physician is unavailable. Situations involving observation status, however, tend to be relatively infrequent compared to the care of all patients that present to the hospital (for example, excessive bleeding or complications during surgery necessitating a longer-than-normal recovery period, or non-specific significant abdominal pain). Further, as emergency room services typically represent the patient's initial medical encounter for new or worsening symptoms, such services focus on identifying, managing, and stabilizing the patient's acute condition. By contrast, observation services are furnished to a patient for whom there is already at least a working diagnosis, and involve ongoing assessment and short-term treatment that is specifically directed at that condition so that a subsequent determination about hospital admission or discharge can be made. (With respect to continuing assessment and treatment, observation services would appear to share some common elements with inpatient care, although the latter involves a condition that is expected to require care for a significantly longer duration, and that also may well require medical intervention at a level of complexity that does not occur on an outpatient basis.)

We recognize that, under section 1886(a) of the Act, the statute defines "operating costs of inpatient hospital services" as including the costs of certain services furnished prior to a patient's admission to the hospital. That is, the costs of certain services furnished prior to an individual's admission as an inpatient are deemed by statute to be operating costs of inpatient hospital services. However, it is worth noting that section 1886(a) addresses costs, and neither section 1886(a) nor section 1861(i) provides that a patient be deemed an inpatient during the time prior to admission for purposes of the 3-day requirement for SNF coverage. Moreover, the deeming requirement in section 1886(a) and the 3-day requirement for SNF coverage in section 1861(i) serve different purposes. The deeming requirement in section 1886(a) was intended to prevent hospitals from "unbundling" services from the inpatient stay and inappropriately seeking separate payment. See 59 Fed. Reg. 1654, 1656 (Jan. 12, 1994). That consideration does not apply in the context of SNF coverage. As discussed above, the purpose of the 3-day inpatient stay requirement for SNF coverage is to target SNF coverage to individuals requiring a short-term, fairly intensive stay in a SNF as a continuation of an acute

hospital stay. The Congress chose to target SNF coverage to individuals who had been inpatients for at least 3 consecutive days; the Congress could have chosen a shorter time, or it could have specified that certain time before admission must be counted for purposes of the 3-day requirement, but it did not. Given the differences in statutory language and statutory purpose, we believe the requirement in section 1886(a) of the Act (to treat certain preadmission costs as inpatient costs) is consistent with not counting time spent in the hospital prior to an individual's inpatient admission as inpatient time, for purposes of the 3-day requirement for SNF coverage under section 1861(i) of the Act.

VII. Provisions of the Proposed Rule

In this proposed rule, we propose to make the following revision to the existing text of the regulations:

- We would revise the regulations at §424.20(e)(2), regarding the performance of SNF certifications and recertifications by NPs and CNSs, to clarify the distinction between "direct" and "indirect" employment relationships. We would also make a minor technical correction in the definition of "HCPCS" that appears in §424.3.

VIII. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IX. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA, September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is major, as defined in Title 5, United States Code, section 804(2), because we estimate the impact to the Medicare program, and the annual effects to the overall economy, would be more than $100 million.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most SNFs and most other providers and suppliers are small entities, either by their nonprofit status or by having revenues of $11.5 million or less in any 1 year. For purposes of the RFA, approximately 53 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards, with total revenues of $11.5 million

or less in any 1 year (for further information, see 65 FR 69432, November 17, 2000). Individuals and States are not included in the definition of a small entity. In addition, approximately 29 percent of SNFs are nonprofit organizations.

This proposed rule proposes to update the SNF PPS rates published in the FY 2005 update notice on July 30, 2004 (69 FR 45775) and the associated correction notices published on October 7, 2004 (69 FR 60158), and December 30, 2004 (69 FR 78445).

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We anticipate that the impact on swing-bed facilities will be similar to the impact on rural hospital-based facilities, which benefit from the case-mix refinement (see Table 12 below).

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs

and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. This proposed rule would not have a substantial effect on the governments mentioned, or on private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that impose substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

B. Anticipated Effects

This proposed rule sets forth updates of the SNF PPS rates contained in the FY 2005 update notice (69 FR 45775), and the associated correction notices (69 FR 60158 and 69 FR 78445) and presents a refinement to the RUG-III case-mix classification system to be incorporated into the Medicare SNF PPS effective January 1, 2006.

As described in Section II.B.4, providers would continue to be paid under the current 44 group RUG-III system from October 1, 2005 through December 31, 2005. Beginning

January 1, 2006, we propose that providers would be paid the proposed new RUG-53 payment.

Based on the above, we estimate the FY 2006 impact to be a net impact of $0 million on payments (this reflects a $1.02 billion reduction from the expiration of temporary payment increases, offset by a $510 million increase from the proposed refined case-mix classification system and a $510 million increase from the update to the payment rates, as explained in greater detail later in this section). The impact analysis in Table 12 of this proposed rule represents the projected effects of the proposed policy changes in the SNF PPS from FY 2005 to FY 2006. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as days or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples are newly-legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition,

changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, the MMA, or new statutory provisions. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with section 1888(e)(4)(E) of the Act, we are updating the payment rates for FY 2006. The BBRA, BIPA, and MMA provided for several temporary adjustments to the SNF PPS payment rates that together, using the most recent data available, accounted for an estimated $1.4 billion per year in payments to the nursing home industry.

We note that in accordance with section 101(a) of the BBRA and section 314 of the BIPA, the existing, temporary increase in the per diem adjusted payment rates of 20 percent for certain specified clinically complex RUGs (and 6.7 percent for other, rehabilitation RUGs) would expire with the implementation of the proposed case-mix refinements in the SNF PPS. As explained in section II.B.3 of this proposed rule, section 511 of the MMA, which provides for a 128 percent increase in the PPS per diem

payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), remains in effect. However, we have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are less than 2,000 beneficiaries who qualify for this add-on payment. The impact to Medicare is included in the "total" column of Table 12.

In proposing to update the rates for FY 2006, we made a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately $510 million.

The aggregate change in payments associated with this proposed rule is estimated to be $0 million for FY 2006. The decrease of $1.02 billion due to the elimination of the temporary add-ons as of January 1, 2006, together with the additional payment due to the proposed refined case-mix classification system of $510 million and the market basket increase of $510 million, results in a net change in payments of $0 million. There are two areas of change that produce this impact on SNFs:

1. The implementation of a refined case-mix classification system under section 1888(e)(4)(G)(i) of the

Act and, consequently, the reduction of the temporary 20 percent/6.7 percent add-ons to the Federal rates for the specified RUG groups.

2. The total change in payments from FY 2005 levels to FY 2006 levels. This includes all of the previously noted changes in addition to the effect of the update to the rates.

The impacts are shown in Table 12. The breakdown of the various categories of data in the table follows.

The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, and census region.

The first row of figures in the first column describes the estimated effects of the various changes on all facilities. The next 6 rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next 20 rows show the effects on urban versus rural status by census region.

The second column in the table shows the number of facilities in the impact database.

The third column of the table shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The

total impact of this change is zero percent; however, there are distributional effects of the change.

The fourth column of the table shows the effect of using the new OMB geographic designations based on CBSAs.

The fifth column of the table shows the effect of the elimination of the add-on for specified RUG groups. As expected, this results in a decrease in payments for all providers.

The sixth column of the table shows the effect of the proposed refinements to the case-mix classification system. Table 12 shows that there is a positive three percent overall impact from the proposed case-mix refinements. Distributional effects are noted for specific providers. For example, hospital-based facilities are expected to receive greater than a 5.6 percent increase in payment, compared with freestanding facilities that show an increase in payments of between 2.4 and 2.9 percent. Additionally, rural Census regions show increases in payments of 3.4 percent.

The seventh column of the table shows the effect of all of the changes on the FY 2006 payments. As the market basket increase of 3.0 percentage points is constant for all providers, it is not shown individually; however, we note that the "Total FY 2006 change" column does

incorporate this increase. It is projected that aggregate payments would not change in total, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from this table, the combined effects of all of the changes would vary by specific types of providers and by location. For example, though facilities in the rural South Atlantic and rural Mountain region experience payment decreases of 2.3 and 1.8 percent respectively, some providers such as the rural Pacific and rural New England show increases of 4.1 and 2.6 percent respectively. Payment increases for facilities in the Rural Pacific area of the country are the highest for any provider type.

Table 12 – Projected Impact to the SNF PPS for FY 2006

	Number of facilities	Update wage data	MSA to CBSA	Eliminate add-on to certain RUGs	Case-mix refine-ments	Total FY 2006 change
Total	15,675	0.0%	0.0%	-6.0%	3.0%	0.0%
Urban	10,599	0.0%	0.2%	-6.0%	2.9%	0.1%
Rural	5,076	0.1%	-0.8%	-6.0%	3.4%	-0.3%
Hospital based urban	1,097	0.0%	0.2%	-6.3%	5.6%	2.5%
Freestanding urban	8,693	0.0%	0.2%	-5.9%	2.4%	-0.3%
Hospital based rural	1,160	0.0%	-0.7%	-6.8%	5.9%	1.3%
Freestanding rural	3,372	0.2%	-1.0%	-5.9%	2.9%	-0.8%
Urban by region						
New England	917	-0.4%	-0.4%	-6.4%	3.0%	-1.2%
Middle Atlantic	1,499	0.2%	0.3%	-6.1%	3.4%	0.8%
South Atlantic	1,739	-0.3%	0.3%	-5.9%	2.6%	-0.3%
East North Central	2,009	-0.3%	0.0%	-5.7%	2.8%	-0.2%
East South Central	531	0.4%	0.7%	-6.0%	2.7%	0.8%

	Number of facilities	Update wage data	MSA to CBSA	Eliminate add-on to certain RUGs	Case-mix refine-ments	Total FY 2006 change
West North Central	836	-0.4%	0.4%	-5.9%	3.7%	0.8%
West South Central	1,093	-0.1%	0.5%	-5.8%	2.7%	0.3%
Mountain	467	-0.2%	0.5%	-5.6%	3.0%	0.7%
Pacific	1,501	1.2%	0.0%	-6.2%	2.7%	0.7%
Rural by region						
New England	139	1.9%	-0.1%	-5.7%	3.5%	2.6%
Middle Atlantic	283	0.0%	-0.8%	-6.0%	3.7%	-0.1%
South Atlantic	612	-0.3%	-1.7%	-6.2%	2.9%	-2.3%
East North Central	947	0.2%	-0.8%	-5.9%	3.5%	0.1%
East South Central	571	0.4%	-0.6%	-6.3%	2.9%	-0.6%
West North Central	1,219	-0.4%	-0.3%	-6.2%	4.0%	0.1%
West South Central	823	0.3%	-0.8%	-6.2%	2.9%	-0.7%
Mountain	298	0.8%	-3.4%	-5.9%	3.8%	-1.8%
Pacific	182	1.3%	0.5%	-4.2%	3.5%	4.1%
Ownership						
Government	693	0.1%	0.3%	-6.5%	3.2%	0.0%
Proprietary	9,317	0.0%	0.0%	-5.9%	2.9%	0.0%
Voluntary	3,493	-0.1%	-0.1%	-6.0%	3.1%	-0.1%

C. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the proposals presented in this proposed rule based on the data for 15,675 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

Table 13 - Accounting Statement: Classification of Estimated

Expenditures, from the 2005 SNF PPS Rate Year to the 2006 SNF PPS Rate Year (in Millions)

Category	Transfers
Annualized Monetized Transfers	$0 million
From Whom To Whom?	No Transfer

D. Alternatives Considered

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the RUG-III payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995.) In accordance with the statute, we also incorporated a number of elements into the SNF PPS, such as case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the Federal rates. Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new fiscal year through the **Federal Register**, and to do so before the August 1 that precedes the start of the new fiscal year.

As discussed previously in section II.B of this proposed rule, we propose to implement refinements to the RUG-III case-mix classification system under section 1888(e)(4)(G)(i) of the Act. At the same time, we continue to evaluate longer-range, more comprehensive changes in the case-mix classification system. One alternative that we considered was to defer proposing refinements at this time until our evaluation of longer-range, more comprehensive changes is complete. However, we believe that the refinements that we are proposing would serve to improve the distribution of payments under the PPS, in a manner that more accurately accounts for the care needs of the most medically complex patients. As noted in section II of this preamble, a number of analyses have demonstrated an increase in the explanatory power (R-square) of the proposed refined case-mix classification system model, compared to the 44-group model that is currently in use. While our additional research may identify more comprehensive modifications, it is not currently known when the results of this research would become available. Therefore, we have decided to propose the refinements discussed elsewhere in this proposed rule. In addition, as noted previously, we specifically solicit comments on the economic impact of the payment changes discussed in this

proposed rule, as well as their potential impact on beneficiaries' access to quality SNF care.

We considered other options intended to help ensure more accurate allocation of payments specifically with regard to non-therapy ancillaries. One of these options included moving the non-therapy ancillary costs used in establishing the nursing case-mix component of the payment rates to a separate, newly created "medically ancillary" component (65 FR 19192, April 10, 2000). In addition, we looked at a number of possible models, both weighted and unweighted, for a new non-therapy ancillary index (65 FR 19248ff.). Finally, we also researched the application of models such as Diagnosis-Related Groups (DRGs) and All Patient Refined DRGs (APR-DRGs). However, at this stage in our analysis, none of these alternatives offered a significant improvement over the RUG-53 model in accounting for the variability of non-therapy ancillary costs.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 424--CONDITIONS FOR MEDICARE PAYMENT

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B--Certification and Plan of Treatment Requirements

§424.3 Definitions.

2. In §424.3, in the definition of "HCPCS" remove the word "CMS" and add the word "Healthcare" in its place.

3. In §424.20, paragraph (e)(2) is revised to read as follows:

§424.20 Requirements for posthospital SNF care.

* * * * *

(e) * * *

(2) A nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section --

(i) Collaboration means a process whereby a nurse practitioner or clinical nurse specialist works with a doctor of medicine or osteopathy to deliver health care services. The services are delivered within the scope of the nurse's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the nurse and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) A direct employment relationship with the facility is one meeting the common law test specified in §404.1005, §404.1007, and §404.1009 of title 20 of the regulations. When this test is not met, the facility is considered to have an indirect employment relationship with any nurse practitioner or clinical nurse specialist who performs nursing services for the facility under §409.21 of this subchapter (however, the performance of only delegated physician tasks under §483.40(e) of this chapter does not, in itself, establish the existence of an indirect employment relationship).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare-Hospital Insurance Program; and No. 93.774, Medicare-Supplementary Medical Insurance Program)

Dated: _____

_____

Mark B. McClellan,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: _____

_____

Michael O. Leavitt,

Secretary.

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